HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 18, NO. 2, ABSTRACTS 156-320. FEBRUARY 1978

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

156. ASHTON, K. **Caring for a divided land.** *Nursing Times*, London, 1977, Oct. 13, vol. 73, no. 41, pp. 1580-1585.

This article is both a collection of opinions and attitudes of nurses, and a description of the health services in Northern Ireland. Some hospitals, including the City Hospital, Belfast, the Royal Victoria Hospital, Belfast and the Lissul Hospital are described. There are also descriptions of the maternity services which are of an extremely high standard, primary care services which act on a 'team' basis and achieve a high level of co-operation with the hospital services, and the excellent disaster and trauma facilities. A special project providing half-way houses for psychiatric patients is also illustrated. Nursing is one of the most popular career choices in Northern Ireland so there are no recruitment problems.

157. TOYNBEE, P. **Hospital.** London, Hutchinson, 1977, 279pp. £4.25

This is a report of five months spent by a journalist watching doctors, nurses and patients in the London Hospital in 1975-76. Separate chapters cover maternity cases, children, the treatment of an actual patient, the work of a nurse, the casualty department, the work of a consultant, the urology section, and the care of geriatric patients.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 210, 276

158. LEOPIZZI, F. Ospedale e servizio sanitario. **[Hospital and health services.]** *Ospedali d'Italia*, Roma, 1977, July/Aug., vol. 14, nos. 7/8, pp. 20-31.

The Italian health service is in a state of transition and in theory this transitional phase should be completed by June, 1978 when the insurance societies will be wound up. The author reviews the contribution and commitment of the Italian Federation of Regional Hospital Associations to the debate on the reform of the health service and discusses the future relationship between the hospitals and the Local Health Units. He emphasises the need for further political measures to ensure that the reform goes through smoothly.

159. ZALÁNYI, S. Az egészségügy 1976. évi gazdálkodása. **[Financial management of public health in 1976.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1977, Sept., vol. 15, no. 3, pp. 312-326.

The report of the Ministry of Health in Hungary, reviews the health of the population and its continuing improvement. The number of hospital beds was increased by 2,300, and with the provision of 1,900 additional places almost 52,000 children can be accommodated in crèches. The polyclinic capacity was raised by 500 consultation

hours per day and by the organization of 74 medical districts for adults and children. More than 2000 million forints were spent on the construction and equipping of health facilities. The running costs of the health and social organizations were 13,000 million Ft, exceeding the previous year's total by 8.1 per cent. The number of health personnel is more than 175,000, although the provision of an adequate supply of manpower still remains a difficult problem.

160. BORDE, D. La clinique Tiphaine à Paris: quand clinique rime avec sympathique . . . **[Tiphaine Clinic, Paris: when clinic rhymes with sympathetic . . .]** *Argus des Collectivités*, Paris, 1977, Aug./Sept., vol. 25, no. 291, pp. 13-16.

The Tiphaine Clinic in Paris, which has 40 beds, mainly in single and double rooms, specializes in maternity cases and surgery of average complexity (surgery of the digestive tract, stomatology, and plastic surgery in particular). There are two small theatres and a labour ward, and the clinic's equipment includes up-to-date X-ray apparatus but only one incubator and one resuscitator for the newborn. The bed occupancy rate is between 80 and 85 per cent. The clinic makes only a small profit and is in need of some modernization. In this and many other respects it is considered to be typical of the French private clinic. Nonetheless it will survive because its patients are well satisfied with the high standard of personal care which they receive. The description of the clinic includes eight photographs.

PLANNING, DESIGN AND CONSTRUCTION

161. ZUCKERMAN, A. M. **Patient origin study profiles service area, evolving patterns.** *Hospitals*, Chicago, 1988, July 16, vol. 51, no. 14, pp. 83-85, 236.

The Hospital Survey Committee is a non-profit health facilities planning agency serving the eight-county Philadelphia standard metropolitan statistical area. In 1975 it undertook a patient origin study in 88 short-stay hospitals; the study concerned itself with community-to-hospital flow patterns for in-patient, out-patient and emergency services. The collection and processing of the data and the reports generated are described and illustrations of the application of the results are given.

162. **Planning a hospital service.** *Middle East Health Supply & Service*, Sutton, 1977, Sept., vol. 1, no. 8, pp. 15-17.

The 500-bed Mafruq Hospital at Abu Dhabi will take only two years from planning to completion. The Swiss Company, Hospitalplan International, specializes in providing a total planning operation for an entire area, not only for current needs, but also for future developments, thereby saving both time and money. Speed in construction also means that the most up-to-date equipment can be installed. Detailed operational plans are undertaken by the company, such as employee job descriptions, and a number of special services, e.g. data processing, are also available. Eighteen months hence it will be seen whether Hospitalplan International can produce in the Middle East the efficient service for which they are already known in Europe.

BUILDING COSTS

163. KNOWLAND, R. **Control of project economy.** *Hospital Development*, London, 1977, July/Aug., vol. 5, no. 4, pp. 10-11; Sept./Oct., vol. 5, no. 5, pp. 24-25, 27-28.

The paper assesses and sets out in the form of a blueprint the more important factors and guidelines which should be taken into account in producing a cost control 'procedure' for incorporation into a project manual concerned with methods required for the running of a major hospital project. The paper is divided into two parts: precontract period; and postcontract period. The former covers: inception of the project; planning and design; production material and tender documents; and contract. The postcontract period covers: construction; and handover, commissioning and final account. If proper control is to be maintained a detailed procedure is essential. It is suggested that there is a need for some sort of body which would represent important clients in dealings with the various professional organizations.

CONSTRUCTION METHODS AND BUILDING MATERIALS

164. WATERS, B. **Hospital treatment.** *Building*, London, 1977, July 22, no. 29, pp. 64-68.

Phase I of the redevelopment of Glasgow Royal Infirmary has been under construction for three and a half years and is due for completion in 1980. It will rehouse the out-patient accommodation and add 216 beds and extensive teaching facilities. It takes the form of a three-storey podium which, apart from service areas, completely covers the available land, and houses vehicle access, parking and plant rooms at ground level, operating theatres on the first floor and the out-patient department on the second. Above the podium are a four-storey ward tower and a five-storey teaching, research and administration tower linked at each level. A maternity tower is intended to be added above the same podium in Phase II. Brief details are given of the construction and a site plan and nine photographs of the building under construction are included.

HOSPITAL DESIGN

165. BILLING, A. **Concept of the nucleus hospital. Part 3. Departments.** *Nursing Mirror*, Sutton, 1977, July 28, vol. 145, no. 4, pp. 17-20.

Previous papers described the philosophy of the nucleus hospital and the details of in-patient accommodation (see *Hospital Abstracts*, Vol. 17, Abstracts 1225, 1693). The choice of departments will depend on the needs of each local community and the services already there. This paper gives a brief description of those departments which have already been designed: geriatric, children's, maternity, out-patient, adult day-care, treatment suite, accident and emergency, operating, sterilizing and disinfecting unit, and intensive therapy/coronary care. The paper, which concludes the

series, also gives information on the use of activity data in the briefing system for this development. A plan and samples of activity data sheets are included.

166. Pleidooien voor integratie: ziekenhuisbouw ter discussie. **[A plea for integration: a discussion on hospital building.]** *Instelling-Management*, Amsterdam, 1977, Sept. 28, vol. 9, no. 9, pp. 13-17.

The paper reports a series of comments by Dutch and Belgian writers on the results of a 1975 competition on hospital building design. Out of the 24 entries four trends emerged: architectural integration of a hospital with its surroundings and other health centres; maximum building heights of four storeys; a lively variety in design and emphasis on creation of a social atmosphere. Criticisms were made that many ideas were too idealistic, not always practical and oriented towards the needs of the specialists rather than those of the patients. On the 'place' of (psychiatric) health care in society four key words emerged: decentralization, integration, flexibility and open planning. Psychiatric care in the Netherlands is thought too sheltered compared with 'normalization' in countries like Great Britain and Sweden. Some progress, however, is being made and examples are given of individual institutions with normalization plans in the form of small family homes with wardens, small flats and working communities. On hospital building in towns the emphasis seems more on social and practical integration of buildings than on the architectural consequences. For future planning it is recommended that there should be consultation among all parties concerned, a working out of the programme, setting up of a co-ordinating council and regional involvement. The paper includes six design sketches and four pictures.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See Abstract No. 164

DESIGN OF SPECIAL DEPARTMENTS

See Abstract Nos. 222, 246, 290

DESIGN OF SPECIAL HOSPITALS OR UNITS

167. **Lightwood House, Norton: building study.** *Architects Journal*, London, 1977, July 13, vol. 166, no. 28, pp. 61-75.

This unit for mentally handicapped patients occupies seven acres of a 31-acre site designated for a district general hospital in south Sheffield. The complex consists basically of a 115-place adult day care unit and four residential units each divided into two 12-person living areas, the whole brought together by a series of covered links. Existing adjacent houses have been converted into staff residential accommodation. An appraisal of the unit by a doctor covers communal facilities, the bedrooms, the day centre, administrative wing, the grounds, and organization. It is concluded

that the scheme is a success in achieving a domestic, intimate and real human scale throughout, with complete avoidance of the institutional environment. The article includes plans, 29 photographs and cost summary, analysis and comment.

GUIDING AND SIGNPOSTING

168. **Planning, flexibility, and growth enable hospitals' signage systems to meet many needs.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 54, 57-58.

The essential feature of hospital signs and the development of a sign system for an individual hospital are discussed. Some aspects of four projects in California are given, with photographs: Saint Joseph Medical Center, Burbank; City of Hope National Medical Center, Duarte; San Antonio Community Hospital, Upland; and Hollywood Presbyterian Medical Center, Los Angeles.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

169. WILKINS, R. D. **Installation and setting to work.** *Hospital Engineering*, London, 1977, Aug., vol. 31, no. 6, pp. 11-15.

This paper describes the procedures which are the responsibility of the contractor's commissioning engineer from design inception to the conclusion of performance testing in the commissioning of building services in hospitals. It covers: pre-commissioning information requirements (functional schematic diagrams, plant specification drawings, isometric drawings, schedules of equipment, electrical drawings); planning of site works; works testing (control panel functional testing, mechanical plant); pre-commissioning site visits; site commissioning; setting to work (plant alignment, switchgear); support services for major plant (provision of false loads, boiler plant, refrigeration plant); and performance testing (maximum load performance, minimum load performance, heater and cooling batteries). The paper serves to illustrate that major plant commissioning is a complex process requiring meticulous planning.

ELECTRICAL INSTALLATIONS AND EQUIPMENT

See also Abstract No. 179

170. POCOCK, S. N. **The proposed 16 amp plug and socket system in UK hospitals?** *Journal of Medical Engineering and Technology*, London, 1977, July, vol. 1, no. 4, pp. 213-215.

A draft BSI standard details a three-pin socket rated at 16 amps, 250 volts proposed by the International Electrotechnical Commission and discussed in this article with reference to use in United Kingdom hospitals. Protection against accidental contact is provided by a rectangular recess in the insulating material or a raised skirt round

the plug body. Protective shutters, a standard UK practice, can be included, but a fuse in the plug is omitted. Moulded-on plugs look neat but still suffer wear and tear and will be a disadvantage in hospitals where cable lengths need to vary greatly. Also, the condition of the connections inside the plug cannot be inspected easily. Continuity of service from electromedical equipment is of prime importance, and with several 16 amp sockets on a circuit protected at 20 amps it would be harder to detect a fault than with the 13 amp system, and more than one piece of equipment may be put out of action at any one time. Under the new proposals, the mains cable or cord will no longer be protected by low value fuses as in the 13 amp system. This country would be well advised to resist the 16 amp system in the hope that other countries will realise the value of integral shutters and a fuse in the plug.

171. HOFFMAN, H. Impianti elettrici in locali per uso medico. **[Electrical installations to premises licensed for medical use.]** *Tecnica Ospedaliera*, Roma, 1977, June, vol. 7, no. 6, pp. 48-52.

This is the second of two articles introducing German safety standards for electrical equipment to an Italian audience. The standards described include those referring to: the prevention of electric shocks; permissible contact tension; connection of the supply to neutral with the centre of the transformer connected directly to the earth; potential equalization; differential F1 switches; the protection conduction system for operating theatres; the reduced tension supply; emergency generators; and regulations governing the use of electro-medical equipment in areas where potentially explosive anaesthetics are used. Factors which may affect recordings on electro-medical measuring instruments, such as the electrical or magnetic fields of high voltage equipment, are also discussed, and there are three explanatory diagrams.

COMMUNICATION SYSTEMS

See also Abstract Nos. 260, 271

172. WEBB, J. M. **Pocket pagers cut hospital noise, keep staff mobile and accessible.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 93-94, 96.

Three years ago, the University Hospital of Albert B. Chandler Medical Center, Lexington, Ky., installed a radio voice pocket paging system to meet its particular communication needs. The basic equipment features, special and optional features, and operation and upkeep of the system are described. Since the system was installed, the number of calls on the hospital's in-house loudspeaker voice paging system has decreased from 5,000 to 800 per day; each call is now repeated twice instead of four times. This has allowed two full-time operator posts to be abolished. In addition a quieter atmosphere for patients has been provided.

173. Impianti interfonici centralizzati per ospedali e cliniche. **[Centralized intercom installations for hospitals and clinics.]** *Tecnica Ospedaliera*, Roma, 1977, June, vol. 7, no. 6, pp. 58-63.

The features and mode of operation of the electronic Com-Center are described. Circuits for patients, nurses, doctors, administrators, and technical and maintenance staff can be connected to a central switchboard where the operator transfers the

messages. Simply by pushing a button on the bedside unit, which also incorporates a microphone, the patient can speak to the operator, and she can either answer his query herself or send a nurse to his bedside. Monitoring equipment can be attached to the bedside unit and an alarm bell will ring automatically if pre-set values are exceeded. For security reasons, this bell can only be switched off at the bedside. Microphones for communication between the central operator and nursing staff are installed in each room. Bleepers are used to contact the medical staff. The advantages of the system are discussed and the description is illustrated by six photographs.

TRANSPORT IN GENERAL

See Abstract No. 262

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 233

174. SJUKVÅRDENS OCH SOCIALVÅRDENS PLANERINGS- OCH RATIONALISERINGSINSTITUT. Driftekonomi för intallationer—periodisk funktionskontroll. **[Operating economy for installations—periodic functional inspections.]** (Spri råd 7.7) Stockholm, Spri, 1977, 42pp.

This recommendation deals with the operating economy of installations and buildings within the framework of building management and construction. The importance of following-up and monitoring operating costs has been demonstrated. Aspects covered by the recommendation are: functional inspections and procedures; follow-up of utility costs; and methods of checking heat insulation. Functional inspection of installations should be carried out at three-to-five-year intervals and may be combined with building inspections for the long-range planning of building maintenance. A series of appendices is included covering such aspects as: directions for functional inspection and measurement; forms for requirement specification and functional inspection; thermography; and recommendations for saving energy. A bibliography of 17 items is included.

175. PLUNKETT, H. D. **Good maintenance management means big savings.** *Dimensions in Health Service*, Toronto, 1977, Aug., vol. 54, no. 8, pp. 32-34.

Maintenance managers in hospitals can reduce maintenance costs by: (i) buying reliable and up-to-date equipment; (ii) limiting and controlling use of the building where possible; (iii) having a clear policy with regard to payment; (iv) employing qualified and experienced maintenance staff and providing opportunities for in-service training; and (v) keeping records of the materials used and the time taken by whom and for what task. The maintenance department should have rules laid down concerning maintenance requests, repair orders and hours of work. It should also have arrangements for an emergency repair system and set up a preventive maintenance plan for both building and equipment. With the advent of sophisticated modern equipment, user instruction is important, especially for those who trained in maintenance many years ago.

EQUIPMENT, FITTINGS, FURNITURE

FLOORS AND FLOOR COVERINGS

See Abstract No. 248

BEDS, COTS, ETC.

176. FRENCH, D. J. **The inhospitable hospital bed.** *Nursing Mirror*, Sutton, 1977, Sept. 1, vol. 145, no. 9, p. 25.

A treatment unit, combining a bed and a chair, would make nursing the elderly patient easier and give him a greater degree of independence than a conventional hospital bed. Such a unit, consisting of a tubular bed frame with a rigid mattress base divided into three sections, could be easily and cheaply constructed. The sections could be slotted into the frame and a three-part over-mattress laid on top. Removal of a segment of the mattress would allow the patient to sit up, and a lower tier could provide a 'well' in which he could rest his feet. By using the toe-stop the patient could hold on to the bed rail and haul himself into a standing position. At night, a thin mattress would provide an unbroken surface to lie on. Diagrams illustrate other uses of the bed unit.

177. TREXLER, P. C., EMOND, R. T. D. and EVANS, B. **Negative-pressure plastic isolator for patients with dangerous infections.** *British Medical Journal*, London, 1977, Aug. 27, vol. ii, pp. 559-561.

The isolation system described consists of a workspace and a bed, placed within two separate but interconnected isolators. Manipulations within the isolated space are carried out through half-suits, and air filters attached to the bed isolator prevent contamination of the ventilation system. All materials are introduced and removed through a port in the supply isolator by use of a plastic bag, and liquid waste is removed through a funnel. The isolator should be sited in a large room in a high security unit. The procedure is described for removing a convalescent patient and for one who has died. Electronic monitoring equipment and intravenous infusion can both be used in the isolator and radiological examinations are possible, but haemodialysis and artificial respiration cannot be performed. Over the last year, seven patients suspected of having infections caused by Lassa, Marbury or Ebola viruses were nursed in the isolator for a total period of 52 days. The patients were comfortable and nurses gained confidence once they realised that nursing techniques were practicable within the isolator.

178. RESWICK, J. B., NICKEL, V. L. and SIMOES, N. **Rancho flotation bed.** *Prosthetics and Orthotics International*, Hellerup, 1977, April, vol. 1, no. 1, pp. 47-51.

Although water flotation beds provide acceptable pressure distribution, the fact that the patient is almost totally submerged has led to a number of problems. In order to overcome these problems, the Rancho flotation bed was developed at Rancho Los Amigos Hospital, Downey, Calif. It is basically similar to a water flotation bed

but uses a fluid of density two (twice as heavy as water), in which the patient floats half submerged. The fluid is a colloidal suspension of pulverized Bayrite and water which is kept homogeneous by the addition of thixotropic clay called Bentonite. The fluid is contained in a vacuum-formed plastic tub covered by a thin, oversize plastic sheet. It is heated to a temperature of 85° to 90°F by an electric unit on the underside of the tub. Over 200 patients have been treated on the beds with no occurrence of new pressure trauma and with general improvement of existing ulcers. The bed is a successful aid to nursing, eliminating the need to turn patients for pressure reasons and allowing patients to remain in a position which is more comfortable. It is also more suitable for other nursing care. Photographs of the prototype and the model, now in commercial production, are included.

LIFTING DEVICES, HOISTS

See Abstract No. 264

MEDICAL EQUIPMENT

See also Abstract No. 252

179. GAIKHORST, G. and KOIVISTO, E. **Current problems in the standardization of medical electrical equipment.** *Journal of Medical Engineering and Technology*, London, 1977, July, vol. 1, no. 4, pp. 203-208.

The progress towards a coherent policy of international standardization of electrical equipment used in medical practice is reviewed against the background of existing legislation in Western Europe. The work of the International Electrotechnical Commission and the implications of the EEC in this context are discussed, as well as the general philosophy of the safety of medical electrical equipment in relation to standardization.

180. CARA, M., BROUARD, S. and MONFRAIS, J. L. Réglementation de l'appareillage médical: réglementation des appareils de ranimation et d'hémodialyse. [**Regulations on medical equipment: regulations for resuscitation and haemodialysis equipment.**] *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Aug./Sept., vol. 32, nos. 383/384, pp. 41-50; summaries in English, German, Spanish and Italian, pp. 49-50.

The authors describe the current French definitions and classifications of equipment for resuscitation and haemodialysis. The equipment is classified according to function, conditions of use, mode of action, method of control, principle employed, and type of energy used. This classification is cumbersome and incomprehensible to the uninitiated; however, it is difficult to find a better one. The Ministerial regulations and orders relating to this type of equipment are listed and analysed; it is pointed out that these have been introduced piecemeal as the need for them arose. The procedures for obtaining official approval for new equipment are described. Although official approval is intended for the use of public bodies, all potential purchasers of new

equipment are strongly advised to buy only officially approved equipment. The accompanying two figures and six tables list the available types of equipment and the tests carried out on them.

ELECTRONIC EQUIPMENT

See also Abstract No. 178

181. THORP, J. **Economic considerations in choosing electronic equipment.** *Hospital Engineering*, London, 1977, Sept., vol. 31, no. 7, pp. 20-22.

Rapid changes in electronics make it necessary to be cautious in buying decisions. It is important to consider not only the assessment of the product but also the end result when using it—primarily the benefit of the patient. Electronic equipment in health services can be divided into: equipment for general technical use; and equipment interacting with the patient. The former does not differ very much from that in industry, but industrial economics are not sufficient for the latter. The general economic theories involved are discussed and four practical examples are given; head scanners; total body scanners; computer electrocardiogram evaluation; and cardiac pacemakers. It is pointed out that sophisticated technical devices need new staff to ensure that they are properly used and maintained. The author stresses the potential of electronic equipment, cost analyses and the importance of setting priorities, education and training, and maintenance.

STAFF GENERALLY

STAFF COMPLEMENTS

182. ZALÁNYI, S. Az egészségügy munkaerőhelyzete. **[Manpower situation in public health.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1977, Sept., vol. 15, no. 3, pp. 296-311.

Health manpower in Hungary increased by about 30,000 during the fourth Five-year Plan period (1971-1975) and the same increase is envisaged for the next five years. However, provision must also be made for the replacement of about 34,000 members of staff leaving (retirement and personal reasons) at the same time. Considering the large number of vacant posts (five to six per cent), the intensity of the labour turnover (about 15 per cent), the heavy workload affecting first of all the hospital nursing staff, and the lack of applicants for posts as ancillary workers, complex measures will have to be taken to remedy this situation. Solutions include: raising salaries; providing housing; building nurses' homes; improving mechanization; improving the education and training systems; and a fuller use of the opportunities offered in management and work organization.

RECRUITMENT

See also Abstract Nos. 182, 311

183. Tsui, A. **Diagnosis of turnover can convert causes to assets.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 157-158, 161-162.

It is generally accepted that staff turnover in hospitals is high and extremely costly. In order to find out where the bulk of turnover lies, analysis of various types of data is necessary. They include: analysis of termination data over a period of years by department, job classification and status; turnover cost studies; and comparisons with other hospitals. Reasons given for leaving on termination documents may not present a true picture. The most effective alternatives include exit interviews, post-termination questionnaires, staff committees, attitude surveys and correlation studies; each of these is discussed. The most logical and effective way of reducing turnover is to apply the basic principles of staff relations and personnel management. The more important of these are: a good staffing policy; induction and orientation programmes; good communications; proper supervision; adequate remuneration; career development; and performance evaluation.

CONDITIONS OF SERVICE

See Abstract No. 238

STAFF MANAGEMENT

See Abstract Nos. 198, 201, 207

STAFF RELATIONS

See Abstract Nos. 200, 201

STAFF TRAINING

See Abstract Nos. 188, 202-205, 301

STAFF WELFARE

See also Abstract Nos. 199, 231

184. Calcopietro, M. Il rendimento del personale e l'assenteismo. **[Staff output and absenteeism.]** *Tecnica & Metodologia Economale*, Firenze, 1977, July/Aug., vol. 16, no. 4, pp. 261-265.

In a group of hospitals in Rome, payments for overtime working constitute 38 per cent of the total wages bill. The absenteeism rate is 11 per cent and when this is added to holidays and days off it means that 25 per cent of the staff are absent on any one day. The author proposes various measures to ensure that any absence from work is for legitimate reasons only and that the overtime claimed for has actually been worked. These include in particular the introduction of a central electronic system to check the presence of staff in the building at any time. The cost of installing such a system could be offset by the resulting savings in payments for overtime.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

See also Abstract No. 301

185. CULLEN, R. J. and BARNES, R. H. **Training nonphysicians to help manage patient care review.** *Hospital Medical Staff*, Chicago, 1977, July, vol. 6, no. 7, pp. 10-16.

A training programme for Health Care Review (HCR) co-ordinators has been developed by the Health Care Review Center in Washington, in co-operation with community hospitals and the Office of Research in Medical Education of the University School of Medicine. The course was tested on 15 co-ordinators selected from hospitals that were willing to appoint the student as their HCR co-ordinator, implement a comprehensive review and help to evaluate the training scheme. The students learned about the requirements and procedures of reviews, and, on the practical side, helped with reviews in their own hospitals, thereby learning to communicate with physicians and other members of the hospital staff. Finally, they analysed the reviews in detail and developed procedure manuals. Depending on the co-ordinator's normal work in the hospital, for example, as a medical records officer or as a nurse, he or she may be responsible for certain parts of the review, and delegate other parts to those more suitably qualified, but both may be trained together in review techniques. When a review pinpoints a problem the co-ordinator cannot initiate action, but can be a useful agent of change.

MEDICAL STAFF

See also Abstract No. 291

186. WILSON, G. and BEGUN, J. W. **Trends in physicians' patient volume.** *Inquiry*, Chicago, 1977, June, vol. 14, no. 2, pp. 171-175.

This examination of data on patient contacts per physician from 1959 to 1974 in the United States indicates that, contrary to expectation, patient volume has not increased. It is suggested that any increases in patient volume have been more than offset by increases in the specialization of care. It is difficult to draw implications from the changes, but the data add weight to the contention that Americans have been paying for more specialized care rather than increased availability of basic primary care. The data also suggest that efforts to increase physician productivity in terms of the volume of patient visits may be more than offset by advances in technology that increase the specialization of the care rendered. The decrease in patient contacts per physician between 1959 and 1974 represents a 'loss' of the services of the equivalent of about 21,000 full-time physicians in 1974. It is very likely that increased specialization has resulted in higher quality service, but the trade-off between cost and specialization must be considered.

187. SUMERLING, R. W. **Outlines of medical negligence.** *Health Trends*, London, 1977, Aug., vol. 9, no. 3, pp. 51-52.

Negligence is the tort on which the doctor's duty to provide reasonable care for his patient rests and the law defines the circumstances in which this care must be exercised. The article describes a number of cases in which negligence was alleged and the doctor's skill called into question. The decision in nearly every negligence case depends upon expert opinion, but a doctor is not negligent if he acted in accordance with an accepted medical practice, even although opposing expert views were given. A causative link between a negligent act and the injury suffered by the plaintiff must be established. Also, a doctor must be judged by the standards and knowledge current at the time, and not in the light of subsequent discoveries. Once negligence has been proven, it is only damage foreseeable as a result which can be compensated. When a patient dies as a result of negligence, dependent family members can recover their loss under the Fatal Accidents Acts.

188. SAFAR, P. **Organization and physician education in critical care medicine.** *Anesthesiology*, Philadelphia, 1977, Aug., vol. 47, no. 2, pp. 82-95.

Critical care medicine is regarded as covering resuscitation, emergency care for life-threatening conditions and intensive care. This paper first discusses the broader concept and then focuses on the intensive care unit (ICU) and its medical staff. Aspects covered include: ICU organization, types of ICUs, regionalization, ICU policies and medical staffing, and medical staff education. Among the conclusions drawn are: (i) the trend for critical care medicine to become a subspecialty of anaesthesiology, medicine, surgery or paediatrics is viable; (ii) combined emergency care and critical care education by interdisciplinary programmes should be upgraded for medical students and residents in all clinical disciplines; (iii) critical care medicine fellowship training should be expanded to meet manpower needs for ICU leadership, to improve standards and to foster research; (iv) all anaesthesiologists should be trained to be capable of functioning as consultants in resuscitation and respiratory intensive care; and (v) their involvement as leaders or team members in critical care will depend on the individual's competence, interest, availability and financial considerations. A list of 120 references to the literature is included.

NURSING STAFF

See also Abstract Nos. 156, 223, 265, 272, 284, 296-298, 311

189. KERRANE, T. **Challenge of changing patterns in nursing.** *Health and Social Service Journal*, London, 1977, Sept. 2, vol. 87, no. 4556, pp. 1244-1245.

Gradually nurses are taking over more and more procedures which have been traditionally regarded as requiring the doctor's skills. This paper examines the effect of these developments on traditional care. The author, a chief nursing officer, takes a critical look at the changing role of his profession and concludes that before accepting extended duties they should ensure that the patients' basic nursing needs are being satisfied.

190. CROSS, E. D. **Nursing research in the Veterans Administration.** *Nursing Research*, New York, 1977, July/Aug., vol. 26, no. 4, pp. 250-252.

For many years the Veterans Administration Nursing Service (VANS) has recognized the importance of research in supplying scientific answers to nursing questions and in improving the quality of care available to patients. From the beginning VANS has endeavoured to develop a partnership between and among administrators, educators, investigators and practitioners in achieving to best possible patient care. Brief details are given of some VANS research projects. Problems exist, but the nursing research programme is strong and, it is expected, will continue to be a vital component of the VANS.

191. ELLIOTT, J. E. **Research programs and projects of WCHEN.** *Nursing Research*, New York, 1977, July/Aug., vol. 26, no. 4, pp. 277-280.

The Western Council on Higher Education for Nursing, established 20 years ago, is a consortium of collegiate schools of nursing in the 13 western states. One of its first steps was to hold three regional research conferences. Early research studies had the aims of defining the clinical content of graduate nursing programmes, investigating the nursing content of baccalaureate programmes, and investigating the effectiveness of a leadership programme. A series of 'communicating nursing research conferences' began in 1968, with the tenth being held in May 1977. The Regional Program for Nursing Research Development supports three types of research groups: targeted, non-targeted and utilization; there have been 38 groups with about 200 members. Several information systems have been created to meet identified needs of nurses in research in the region. An advisory committee of 12 assists staff in planning and policy making.

192. GIMBLE, J. G. **Identifying the nurse practitioner.** *Journal of the American Dietetic Association*, Chicago, 1977, March, vol. 70, no. 3, pp. 282-284.

This paper examines the origin, definition, education and increased responsibilities of the nurse practitioner with the aim of replacing doubts with greater acceptance and improved collaboration with other health team members, particularly dietitians. The responsibilities undertaken by nurse practitioners have included: screening patients; routine assessment of health status; managing the care of selected patients; consulting and collaborating with physicians and other health professions in planning and instituting health care programmes; and instituting care during normal pregnancies and deliveries, providing family-planning services, and supervising the health care of normal children.

193. KALISCH, P. A. **Weavers of scientific patient care: development of nursing research in the U.S. armed forces.** *Nursing Research*, New York, 1977, July/Aug., vol. 26, no. 4, pp. 253-271.

After outlining the history of nursing services in the United States armed forces, this paper presents an overview of the development and current status of nursing research in those services. A list of 262 references to the literature is included.

194. SPECTOR, A. F. **Regional action and nursing research in the south.** *Nursing Research*, New York, 1977, July/Aug., vol. 26, no. 4, pp. 272-276.

For much of the 30 years since the Southern Regional Education Board was founded, the main concentration of effort has been directed towards strengthening existing collegiate nursing programmes and establishing new ones. Now, in the 1970s, a major commitment to nursing research has been made. One three-year regional project is now under way. It is clinically oriented and designed to stimulate research that will result in advantages for nursing practice. The committee appointed to oversee the project has carried out a questionnaire survey of current research studies in the region. A brief analysis is given of the 207 studies reported. A new project entitled 'Nursing research development in the South' began on 1 February 1977 and will concentrate on education.

195. LEVERT, A. J. **Nursing in Europe: the Netherlands.** *Nursing Mirror*, Sutton, 1977, Sept. 29, vol. 145, no. 13, pp. 29-30.

This article describes nurse education in the Netherlands and is part of a series dealing with nursing education in EEC countries. The various methods of nurse training in the Netherlands include a three and a half-year general course; a three-year course in psychiatry; a course in mental subnormality lasting three years; and in recent years two vocational courses have been introduced. All training schools are hospital based; students are regarded as part of the workforce and are salaried. The minimum entry age to the general course is 17 and a half. Theoretical instruction is given for at least 1,060 hours with 86 weeks of clinical training. The clinical training includes: 24 weeks each for medicine and surgery; 12 weeks for paediatrics; and 16 for maternity. The medium level vocational course lasts for three years and approximately 2,280 hours of theoretical and 1,320 of clinical training are given. The higher vocational course lasts for four years, with a total programme of 4,500 to 4,800 hours of training and covers the same subjects as the general course but in more depth.

196. WEINRICH, R. **Nursing in Europe: the Federal Republic of Germany.** *Nursing Mirror*, Sutton, 1977, Oct. 20, vol. 145, no. 16, pp. 31-32.

This article looks at nursing education in West Germany and is part of a series investigating nurse education in the EEC. Basic courses in West Germany last for three years with a minimum entry age of 18 years. The courses are the responsibility of the Federal Republic and culminate in a State examination. The nursing schools must give a minimum of 1,200 hours theoretical instruction, and practical training is given on the wards. No central registration office exists in West Germany and recognition of nursing qualifications is by provincial authorities. Short advanced training courses in management and special areas of care are run by the provincial authorities, although they are not generally recognized by the State and do not enhance basic nursing qualifications.

197. NANDI, P. K. **Cultural constraints on professionalization: the case of nursing in India.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 3, pp. 125-135.

This paper focuses on the occupation of nursing in India and attempts to analyse

the interplay between occupational and cultural contexts and the development of attitudinal as well as organizational constraints against the attainment of fully professionalized nursing in India. The argument is not that Indians underrate conservation of life, alleviation of suffering and promotion of health—the three basic tenets of nursing ethics. It is that those who are trained for and charged with these responsibilities are at the same time denied decent working and living conditions, and that their work is looked down upon as unseemly. The nurse's lack of professional status, her low and unattractive salary, the inadequate recognition of her services by the community, the little incentive for quality performance, the hardship of rural assignment without satisfactory compensation, and the insufficient and inadequate university training programmes are the result of the lack of independence of the occupation from the cultural context. Lip service to the nobility and humaneness of the profession without corresponding movement towards providing its practitioners with a noble and humane environment has deterred the growth of professionalism in nursing in India to the detriment of the profession and of society as a whole.

198. MEINTEL, P. and RHODES, D. E. **Clinical career ladder rewards RNs.** *Hospital Progress*, St. Louis, 1977, Aug., vol. 58, no. 8, pp. 36-37, 40-41, 44, 46, 48.

The 500-bed, acute care Mercy Hospital, Des Moines, Iowa, carried out a one-year project to define levels of clinical nursing required for meeting patient needs and to provide incentives to attract, retain and motivate clinical nurses. Steps involved were: establishing a working task force; clarifying programme objectives; determining expertise levels; developing level criteria; establishing the unit profile; integrating the career ladder into the overall personnel programme; analysing costs; and implementing the programme. Five levels of expertise were defined: staff nurse I, staff nurse II, clinical nurse I, clinical nurse II, and clinical nurse specialist. The new career pattern allows registered nurses to progress from staff nurse through the clinical or management hierarchy or to change career paths at various levels.

199. FELTON, G. and WARD, J. H. **Regression models in the study of circadian rhythms in nursing research.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 3, pp. 151-161.

This paper demonstrates the fitting of multiple regression models to data in an investigation undertaken to determine the effects of rotating work shifts around the clock on nurses' sleep patterns, the daily body temperature cycle and excretion patterns of urine sodium, potassium, creatinine and osmolality. Disruption as a result of changing shifts was detected. There was indication of disruption each day on night duty and on post-night-duty days. The degree of disruption was related to: (i) trouble staying asleep; (ii) trouble sleeping because of noise or environmental temperature; (iii) fatigue; (iv) difficulty switching from nights to days; (v) adjusting bowel habits; and (vi) satisfaction with regular work schedule.

200. FRALIC, M. F. **The nursing director prepares for labor negotiations.** *Journal of Nursing Administration*, Wakefield, 1977, July/Aug., vol. 7, no. 6, pp. 4-8.

This article provides practical information and advice on labour negotiations in nursing in the United States of America. It focuses on the role of the Director of

Nursing in effective labour negotiations and stresses the importance of the Director of Nursing acquiring skills in labour relations. One of the most important resources in acquiring information in this field is the hospital labour solicitor. Also outlined are topics that the Director of Nursing should be conversant with: the National Labour Relations Act; NLRB certification, the labour literature and strike procedures. Finally, the article covers conduct during negotiations and personal attitudes and roles.

201. NASH, A. **Conflict relations between nursing supervisors, practical nurses and attendants.** *Journal of Nursing Administration*, Wakefield, 1977, July/Aug., vol. 7, no. 6, pp. 9-11.

This article is based on the author's doctoral dissertation awarded by New York University in 1972 and deals with role and group conflict between nurse supervisors (registered nurses), practical nurses (unregistered nurses) and attendants. The article focuses upon job satisfaction and supervisor/employee relationships in Montefiore Hospital and Medical Centre in New York City. The hospital has a collective bargaining agreement with the local branch of the Drug and Hospital Union. The sample included both men and women and consisted of 22 attendants, 19 practical nurses and 31 supervisor nurses. Data was obtained by interviews and self-administered questionnaires. The attendants had a high level of job satisfaction which was due to the respect of patients, although they felt that the nurses did not appreciate their role. Male attendants in particular were sensitive to supervision by nurses. It was also felt that re-allocation of attendants was a contributory factor to the high turnover levels. The practical nurses, also, had a high level of job satisfaction, but felt that their role was being eroded by registered nurses, and that they were more familiar with the hospital and its procedures and traditions than the registered nurses. The study found that educational persuasion was the principle method of supervision by registered nurses and that this may have been based on the nurses' relationship with the patient. Viewed overall, the study appeared to indicate that there is less conflict between these groups than between management and employees in other organizations.

202. ADDERLEY, B. V. and BROCK, A. M. **Evaluating clinical performance in nursing.** *Journal of Advanced Nursing*, Oxford, 1977, July, vol. 2, no. 4, pp. 355-363.

Evaluation of clinical performance requires that the nurse educator observes behaviour in a specific, goal-directed manner and reports these observations clearly and unambiguously, although it is conceded that beyond basic technical skills there is little consensus as to what constitutes a good professional nurse. The purposes and processes of evaluation are questioned. The concept of evaluation must be broadened to include other clinical performances which include human skills as well as technical skills. An attempt was made to use this broadened concept in two baccalaureate programmes. Two different types of learning activities were developed: a course in independent studies and a clinical conference protocol. The control of students by educators and by the system needs to change towards an individualized programme. The student's role then becomes harder, more responsible and less dependent, the educator's softer, more objective and more professional, and the system becomes more service-oriented and less authoritarian.

203. FERGUSON, M. **Patient-link project.** *Nursing Times*, London, 1977, Sept. 29, vol. 73, no. 39, occasional papers, pp. 129-131.

The Department of Advanced Nursing Studies at the Welsh National School of Medicine has initiated a teaching and learning programme known as the patient-link project. It has three main aims: (i) integration between hospital and community; (ii) integration between theory and praxis; and (iii) integration between cognitive and social learning experiences. The nursing student links himself to a patient, visits his home before he enters hospital and after he returns home. Seeing the patients' home and family will help the nurse to: (i) understand the meaning of illness for the patient; (ii) judge whether its cause may be connected with his environment; and (iii) form ideas on nursing organization and, ultimately, patient care. Both students and patients have expressed enthusiasm for the project, which operates in the students' second year. The departments' tutorial system enables students to share their experiences and communicate openly with their tutors.

204. SPARROW, E. **Continuing education—imperative for nurses?** *Nursing Mirror*, Sutton, 1977, Aug. 18, vol. 145, no. 7, pp. 29-30.

While some nurses are continuing learners, the majority need some form of planned further education to enable them to give the highest standard of care to their patients. It is not easy to find the money or the staff to plan in-service education, but the qualified nurse will want to participate for the following reasons: (i) to achieve promotion; (ii) to view her work from a new angle; and (iii) to remedy lack of experience and competence in dealing with certain problems. The scheme must be a shared learning process for both teachers and taught. The organizers must define their own role clearly and be able to engender enthusiasm for the scheme among all hospital staff. Each course should be different and teaching techniques varied. Time should be allocated for discussion, project work and evaluation of the course. In-service education should cover three phases in the professional life of the nurse: (i) orientation for newly appointed or recently qualified staff, including job description and definition of hospital policies; (ii) in-service training aimed at improving nursing performance and patient care; and (iii) communication of information about the course to colleagues and patients.

205. WHEELER, R. and others. **Nursing assessment.** New York & London, Wiley, 1977, ix, 167pp. £4.95

This volume is a collection of learning modules about a specific subject in the nursing syllabus. Each module follows the same format: pretest; learning objectives; directions; activities; progress checks; and post-test. These modules are designed for use by independent learners but can also be used as a basis for seminars. The aspects covered include: introduction to nursing assessment; the nursing history; physical health assessment; psychosocial assessment; the nursing diagnosis; and the evaluation process.

206. WISEMAN, J. **A nursing audit of basic care—1. Further developments and a critical evaluation.** *Nursing Times*, London, 1977, Oct. 27, vol. 73, no. 43, occasional papers, pp. 137-140.

This article is a follow-up to two previous occasional papers describing nursing

audit procedures in Blackpool Health District, and updates the developments described previously. Since the previous articles [See *Hospital Abstracts*, Vol. 17, Abstract No. 502], audits have been made for Nurse Education Division, Nurse Staff Posts and Theatre Departments and are reported here. An attempt is made to evaluate the information obtained from the audits and this is done by means of questionnaires, analysis of the 'main master' audits and by seminars; the results of the evaluation are also discussed.

207. HABEEB, M. C. and MCLAUGHLIN, F. E. **Health care professionals' role expectations and patient needs.** *Nursing Research*, New York, 1977, July/Aug., vol. 26, no. 4, pp. 288-297.

In a study in five Veterans Administration hospitals in northern and central California, interviews were held with 15 physicians, 15 social workers and 70 registered nurses (hospital and community). The object of the study was to explore the preconceptions they held of the functions of nurses in the placement of patients transferred to convalescent facilities. Two distinct focuses of nursing role activity were identified: preplacement and follow-up. Interview data of all three disciplines suggested a need to strengthen the preplacement component of the acute in-patient ward nursing staff roles, e.g. increased direct communication between ward nurses and convalescent care nurses was suggested. Emphasis was placed on ward nurse preparation of patients regarding acceptance of placement. Physicians thought community placement nurse roles in follow-up activities with convalescent care patients should incorporate additional physical assessment skills, but the community placement nurses themselves and the social workers offered no additional functions for this group.

208. LAUBE, J. **Death and dying workshop for nurses: its effect on their death anxiety level.** *International Journal of Nursing Studies*, Oxford, 1977, vol. 14, no. 3, pp. 111-120.

A two-day workshop for nurses entitled 'Grief in life threatening situations' was organized by the author and a committee of nurses in a large Veterans Administration hospital. The programme was presented through lectures, films, and small group discussions and experiential work. The participants completed a questionnaire to assess their level of anxiety concerning death at the beginning and end of the workshop and four weeks and three months after it. The conclusions drawn were: (i) nurses' level of death anxiety is consistent with the general population; (ii) death anxiety level of nurses is significantly decreased one month after the workshop; and (iii) participation in the workshop tended to result in a lower level of death anxiety among the nurses as much as three months after the workshop. Among the recommendations are: the research should be repeated with other health disciplines; and hospitals should provide in-service programmes on death and dying for their staff.

209. GEOLOT, D. and others. **Emergency nurse practitioner: an answer to an emergency care crisis in rural hospitals.** *Journal of the Royal College of General Practitioners*, Lansing, 1977, Aug., vol. 6, no. 8, pp. 355-357.

This is a description of a nine-month course run by the University of Virginia, USA, to prepare emergency nurse practitioners for an expanded role in emergency departments. The course was established in 1974 and is one of four for nurse practitioners. The course is divided into three-month modules with an educational core common to all

four courses, afterwards focusing on a speciality. The emergency nurse practitioner must develop diagnostic abilities based on case history and examination, then give the appropriate treatment and arrange for any follow-up. Particular emphasis is placed on training in life support techniques. Potential students must be registered nurses with at least two years' experience and priority is given to nurses from areas with minimal emergency facilities. The authors feel that the course has improved the quality of emergency care and that patients are satisfied with the work of the emergency nurse practitioner.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 188, 243, 285

210. ANGELETTI, R. Funzioni e compiti dell' ospedale. **[Functions and duties of the hospital.]** *Ospedali d'Italia*, Roma, 1977, July/Aug., vol. 14, nos. 7/8, pp. 82-99.

The author considers a range of definitions of the functions and duties of the hospital. Most of these definitions reflect one of two concepts: either that the hospital is the central point of the health service or that its basic role is the care of the acutely ill patient. The author offers his own definition: he sees the hospital as a complex of multispecialist services defined and dimensioned with reference to the area which it serves. It is an integral part of the health system and its fundamental role is the treatment of acute illness. It plays a secondary role in preventive medicine, rehabilitation, training, teaching, and research, and in health education for the community.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 175, 181, 286

211. IRELAND, R. C. **Using marketing strategies to put hospitals on target.** *Trustee*, Chicago, 1977, July, vol. 30, no. 7, pp. 25-27, 30-31.

Hospitals are making marketing statements without really practising marketing. The proper application of marketing principles can make a significant contribution to solving some of the problems facing hospitals. Hospitals must gain a deeper understanding of their markets if they are to remain competitive and to optimize their resources. All marketing programmes begin with an analysis of where the organization has been, where it is now, and where it wants to go. The key to success in applying the marketing mix lies in the concept of rightness—the right product in the right place at the right time with the right promotion. Selling is probably not a useful tool for the hospital marketer. 'Marketing communications' is probably a more meaningful term for hospitals than 'promotion'. Advice is given on developing a framework for communications.

212. VERONESI, E. Esperienze e prospettive della regione Emilia-Romagna su costi e rendimenti dei servizi ospedalieri. **[Experiences and prospects in the Emilia-Romagna region with regard to costs and returns of hospital services.]** *Tecnica & Metodologia Economale*, Firenze, 1977, July/Aug., vol. 16, no. 4, pp. 253, 256-260.

The author reviews the progress made in hospital reform in the Emilia-Romagna

Region over the past two years. It is too early as yet to talk of cost-benefit analysis. Funds for hospitals are distributed regionally on the basis of the requirements of the individual hospital and no objective criteria have yet been defined. The amount of money made available is based on past expenditure. In monetary terms expenditure was 10 per cent higher in 1976 than in 1975. A system of accounts common to all hospitals has been introduced, and a quarterly information system regarding expenditure and cash flows has been established. Measures which will facilitate cost-benefit analysis in the future are discussed.

213. Gezondheidszorg in Nederland: financieel-economische analyse van het ziekenhuis (V) **[Health care in the Netherlands V: financial and economic analysis of the hospital service.]** *Instelling-Management*, Amsterdam, 1977, Sept. 28, vol. 9, no. 9, pp. 10-11.

The article (fifth in a series) discusses annual hospital accounts and a comment made by the bank (Algemene Bank Nederland, A.B.N.) which carried out an analysis of the financial-economic position of a large number of hospitals. Closing or re-organization of a hospital can cause financial problems and throw doubts on credit-worthiness of hospitals in general. In a bill now before Parliament a re-organization fund is being introduced to give legal financial assistance. At present all annual accounts have to be sent to the Ministry. The accounts follow a prescribed system of depreciation and their non-profitmaking character is expressed in their balance sheet. New buildings, which during the first years show a deficit because of under-occupancy, are allowed special arrangements for depreciation. Determination of solvability of a hospital causes problems in that its assets are usually small and its financing is mainly from loans. The accounts have to be accompanied by reports on the hospital's clinical and polyclinical activities and by figures on admissions, bed occupancy etc. to be used for statistical purposes (table 1). The A.B.N., in a comment, concludes that the present situation in hospitals, with increasing professionalism and Government involvement, is a phase of transition towards an entirely new structure.

214. Gezondheidszorg in Nederland: financieel-economische analyse van het ziekenhuis. **[Health care in the Netherlands: a financial and economic analysis of the hospital service.]** *Instelling-Management*, Amsterdam, 1977, July, vol. 9, no. 7, pp. 6-8.

The article (third in a series) discusses the percentage of hospital bed occupancy and forms of co-operation between small hospitals. In recent years the percentage of occupied beds in hospitals has been declining due to an increase in the total number of beds and a fall in demand. The latter was due to a shorter average hospital stay resulting from an increase in the number of nursing homes, changed patterns of medical treatment, more polyclinical pre-hospital and after care, and declining occupancy in children's departments. As hospital running costs are for the most part fixed permanent expenses (approximately 80 per cent), the loss of revenue from lower bed occupancy can lead to financial problems. To reduce expenses re-grouping of beds and consequent closing down of some departments are suggested. Small hospitals find it increasingly difficult to meet costs of modern medical techniques and their standards would suffer. Co-operation between their services is becoming essential and in cases of regional over-bedding total mergers are indicated. This includes an

often resented loss of autonomy, difficulties with integration of medical staff, closing down of some hospitals and re-organization of polyclinics. General financing of hospitals is mostly external and co-operation by banks is urged for providing loans. The paper includes details on calculations of bed occupancy and a table on hospital sizes.

RUNNING COSTS

See also Abstract No. 212

215. PHILLIP, P. J. **New AHA indexes provide fairer view of rising costs.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 175, 178, 180, 182.

The first part of this paper attempts to unravel the prevailing misunderstanding about the rising cost of hospital care. In particular, it stresses the need to differentiate between the effects of price increases and greater consumption. Traditional price measures are seen to be inadequate because they fail to separate the 'price effect' from the 'quantity effect'. The American Hospital Association's Hospital Costs Index (HCI) provides a better measure of inflation compared with the measures currently available. The Hospital Intensity Index (HII) is an important adjunct to the HCI, in that together they are able to separate the 'price effect' from the 'quantity effect'. The properties of the two indexes are outlined. Their central purpose is not to explain away rising hospital expenditure. However, by separating 'price effect' and 'quantity effect' they show that greater use and not excessive inflation has led to hospital expenditure claiming an increasing share of the gross national product.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 161, 186, 295

216. MCCLURE, W. **Benefits of reducing excess hospital capacity.** *Hospital Progress*, St. Louis, 1977, July, vol. 58, no. 7, pp. 7, 10-11.

This paper summarizes the main findings of a study commissioned by the United States Department of Health, Education and Welfare to determine whether hospital capacity should be reduced and if so, how. These were: (i) hospital capacity could be reduced by five to 10 per cent by retiring idle capacity and using the remaining capacity more efficiently; (ii) increased hospital capacity of itself causes an increase in hospital use—conversely reduced capacity appears to reduce use; (iii) capacity could be reduced by another 10 per cent or more without harm to health by reducing unnecessarily used capacity; (iv) similar excess capacity, both underused and unnecessarily used, appears to be present in high intensity service facilities; (v) the savings produced could be substantial, but depend crucially upon how reduction is accomplished; (vi) savings from reduction of capacity will be eroded gradually unless hospitals are restrained from increasing excessively the labour and capital intensity of the remaining beds; (vii) while effective reduction would probably restrain excess use and expenditure, if equal attention is not given to restraining demand, patient queuing and the need for utility types of controls may be significant side effects; and (viii) capacity reduction is even more a sociopolitical problem than a technical one.

217. GORNICK, M. **Medicare patients: geographic differences in hospital discharge rates and multiple stays.** *Social Security Bulletin*, Washington, 1977, June, vol. 40, no. 6, pp. 22-41.

Central records are kept of all hospital stays by Medicare patients. This provides the opportunity to examine patterns of hospital use nationwide. This paper focuses on geographic patterns and changes in hospital discharge rates; it also examines the relationships between rates of use and multiple admissions. The data indicate that reductions in length of stay are offset by the rising number of admissions. Examination of multiple stays—a major factor in the number of discharges—shows that states with high rates of discharges have high percentages of patients with multiple stays. Furthermore, in these states the percentage of multiple stays is high no matter what the diagnosis. In other states the rate is low for all diagnoses. These findings suggest that options exist for the provision of care for the same or similar conditions and that geographic patterns appear in the use of these options. An urgent need exists for research to establish the variables affecting use and to explore ways of changing some of the patterns of delivering services.

EMERGENCY ADMISSION, EMERGENCY BED SERVICES

See Abstract No. 291

OFFICE MANAGEMENT AND METHODS

218. **Order central concept.** *Hospital Topics*, Sarasota, 1977, July/Aug., vol. 55, no. 4, pp. 26-29.

During the renovation of the 60-year-old, 277-bed Northern Westchester Hospital Center, Mt. Kisco, N.Y., the administration took a long look at its communications systems and procedures. The resulting information and materials handling network was not achieved through a sophisticated and expensive computer system, but through an unusual approach to paperwork and related procedures. Hub of the operations is the order central desk, pivotal point between departments for the receipt and despatch of service requests. Features of the system include: pneumatic tube system, with stations in each patient room as well as departments; multipart forms designed to serve as request, reporting form and charge slips; and colour-coded laboratory service sets for ease of identification. Brief details are given of the procedures followed. The system has resulted in tangible savings.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 162, 226, 236, 268, 278, 279, 314

219. BECKLEY, R. F. and BLEICH, H. L. **Paper chase: a computer-based reprint storage and retrieval system.** *Computers and Biomedical Research*, London, 1977, Aug., vol. 10, no. 4, pp. 423-430.

Researchers in the Computer Medicine Laboratory, Beth Israel Hospital, Boston, Mass., have developed a computer program that provides easy access to a large

reprint file. The program runs in MUMPS in 1k of core on a PDP-15 computer that can serve over 20 users simultaneously. The collection for which it was designed now contains 9,000 reprints. The system has four general characteristics: (i) the computer file is divided into sections, each corresponding to the collection of an individual scientist; (ii) when a document arrives, its owner assigns to it subject headings that, in addition to title words, become keys to its retrieval; (iii) the authors, title, journal, citation and subjects are then entered into the computer and an accession number is written on the document; and (iv) all entry, editing and searching are accomplished by responding to questions presented interactively by the program and on-line documentation permits easy use of the program without prior experience.

220. WESTIN, A. F. **Computers, health records, and citizen rights.** (National Bureau of Standards Monograph 157) Washington, U.S. Government Printing Office, 1976, xxi, 382pp. $4.55

This report is the result of a two-year research project into the impact of computers on citizen rights in medical record keeping in the United States. Aspects covered include: the world of medical data and citizen rights; trends in computerization of medical data; profiles of organizations using computers; and policy alternatives. A select bibliography is included together with 12 appendices.

221. LEAVITT, M. B. and LEINBACH, R. C. **A generalized system for collaborative on-line data collection.** *Computers and Biomedical Research*, London, 1977, Aug., vol. 10, no. 4, pp. 413-421.

The MIRU (Myocardial Infarction Research Unit) computer group maintains a computer facility and provides technical assistance to physicians engaged in the collaborative study and treatment of ischaemic heart disease. FEDS (Formalted file Editing and Display System) is a structure for files of data stored on a direct access device and a series of routines that access these files. It has been implemented on a Xerox Sigma 3 computer with a 48K memory, that also supports other real-time processes and batch mode applications in background. There are three system files: format file, page description file, and master file directory. Each file, including the system files, is associated with a file description, which provides the storage and display characteristics of that file to the generalized routines. The routines also form the foundation for various application programs, including one that allows a user to construct a variable length clinical record from the data generated by the cardiac catheterization laboratory.

LIBRARIES

See also Abstract No. 219

222. HITT, S. and LYDERS, R. A. **A new library building: the Houston Academy of Medicine—Texas Medical Center Library.** *Bulletin of the Medical Library Association*, Chicago, 1977, April, vol. 65, no. 2, pp. 268-276.

A historical account is given of the Houston Academy of Medicine—Texas Medical Center Library within the setting of the Texas Medical Center, Houston, Texas. The planning, financing and construction of the new library are discussed. The new library

consists partly of a new building and partly of renovated interiors of a building originally completed in 1954. The interior design of the library is discussed. An architectural summary is included showing gross and net footage, source of funds, costs and capacity.

223. WALSER, K. P. **A college course for nurses on the utilization of library resources.** *Bulletin of the Medical Library Association*, Chicago, 1977, April, vol. 65, no. 2, pp. 265-267.

Library user instruction has been a 'no-mans-land' between librarian and educator. Reference librarians at the Duke University Medical Centre Library North Carolina, are now offering a 10 week, 1½-hour-credit library instruction course for nursing baccalaureate candidates. The aim of the course is to provide students with background material on library organization and services, and to familiarize them with basic bibliographic tools relevant to the nursing profession. Lectures are supplemented by homework questions, bibliographies, handouts, and on-line demonstrations. Positive feedback has attested to the value of such a course in the nursing curriculum. It has now been offered four times to the students and the library staff are exploring methods for offering additional instructions not only to nursing students but to other user groups in Duke University's medical complex.

MEDICAL RECORDS

See also Abstract Nos. 220, 221

224. FERNOW, L. C. and others. **An analysis of the use of problem oriented medical records (POMR) by medical and surgical house officers: factors affecting use of this format in a teaching hospital.** *Medical Education*, Oxford, 1977, Sept., vol. 11, no. 5, pp. 341-346.

Problem oriented medical records (POMR) were introduced at Guy's Hospital in 1974 and a booklet giving guidelines for their preparation was distributed to all staff. This paper reports a study to evaluate the use of the POMR format by house officers and to examine the ways in which feedback and attitudes affect this use. One set of case notes a week for 12 successive weeks was selected randomly for each of 28 house officers (14 in general medicine and 14 in general surgery). The notes were scored for use of the POMR format in the data base, initial plans and progress notes. The significant findings were: (i) marked differences in scores among house officers; (ii) those who performed well or badly did so in all three components of the system; (iii) high scores in the medical group identified more problems, with no evidence that their patients were more ill; (iv) scores were better for house officers with favourable attitudes toward POMR and scores were better in the innovative sections if senior staff used the system; and (v) house officers with BA or BSc degrees scored better with initial plans and progress notes. No positive effect of feedback was demonstrated.

225. GRIESSER, G. and others. **Realization of data protection in health information systems: proceedings of the IFIP-WG4.2 Working Conference . . . Kiel 22-25 June 1976.** Amsterdam & Oxford, North-Holland Publishing Co., 1977, xvi, 214pp.

These papers presented at the Working Conference on data protection in health

information systems can be divided into two major groups. The first is composed of articles dealing with the personal experiences gained by authors in their own health information systems concerning data protection; the second considers the more specific and technical aspects to be discussed during the Working Conference: hardware precautions, software techniques and organizational means. A summing-up of the discussions of these 20 papers is included, together with an author and subject index.

226. FROOM, J., CULPEPPER, L. and BOISSEAU, V. **An integrated medical record and data system for primary care part 3: the diagnostic index manual and computer methods and applications.** *Journal of Family Practice*, New York, 1977, July, vol. 5, no. 1, pp. 113-120.

The diagnostic index is a compilation of lists of patients who have received the same diagnosis. The E-book is a diagnostic index suitable for use in primary care introduced in Great Britain by Eimerl in 1960 and since modified and adapted there and in other countries. This paper describes the establishment, maintenance and application of both manual and computer E-book indexing processes in the University of Rochester Family Medicine Training Program. Each has its advantages. Immediate, inexpensive access to diagnostic information makes the manual version desirable for solo or group practices. In the Rochester Training Program, despite extensive use of the computer index, all trainees are required to become thoroughly familiar with the manual version. The computer index is far more versatile. The capacity for computer linkage with other parameters of patient care render this version most appropriate in large, research-oriented groups and training or academic programs.

227. MELUM, M. M. **Balancing information and privacy.** *Hospital Progress*, St. Louis, 1977, July, vol. 58, no. 7, pp. 68-69, 79.

A survey by the Minnesota Hospital Association of its 191 member hospitals indicated a high degree of patient access to their own medical records and a need for better methods of monitoring third-party access to these records. Using the survey results as a guide the Association developed voluntary standards for privacy of medical records; these standards are reproduced. The objective of balancing access to the medical record and the privacy of the record is likely to become more difficult with increasing government involvement in the health care system. It is believed that the standards presented provide a foundation upon which the hospital industry can build to provide effective action to meet this objective.

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 187, 220, 227, 269, 312

228. AMERICAN HOSPITAL ASSOCIATION. SPECIAL COMMITTEE ON THE REGULATORY PROCESS. **Hospital regulation: report.** (Chairman: T. Stewart Hamilton) Chicago, Ill., American Hospital Association, 1977, x, 188pp. $5.00

This report recommends actions that the American Hospital Association and its membership can take to influence more effectively the regulatory process and the legislation on which it is based. The report also explores how hospitals can increase

their effectiveness and influence in the regulatory process. Aspects covered include: history of health care regulation; the hospital industry's view of regulation; criteria for effective regulation; special problems of health care regulation; utilization regulation; hospital facilities regulation; hospital payment regulation; and the legislative and rulemaking processes.

229. ASHBY, J. L. and others. **Elements in successful risk reduction programs.** *Hospital Progress*, St. Louis, 1977, July, vol. 58, no. 7, pp. 60-64, 75.

An in-depth study of four 'successful' hospital risk reduction programmes resulted in the development of 14 model elements for such programmes. Six of these are considered most important for any hospital initiating the development of such a programme: single administrative responsibility for the programme; risk detection procedures; liability control procedures; delineation and assignment of staff level functions; a committee structure; and methods of obtaining physician participation. The essential features of each of these elements are discussed.

230. NICOLAI, M. Il sistema di controllo sugli enti ospedalieri e la loro configurazione giuridica (III). **[The system of control of hospital institutions and their legal form (III).]** *Tecnica & Metodologia Economale*, Firenze, 1977, July/Aug., vol. 16, no. 4, pp. 248-252.

The author examines the hypothesis that Italian hospitals are autonomous local institutions, since they are generally run by the elected representatives of the local community. He shows that this autonomy is limited both by legislation and by national and regional hospital planning policy, and in particular the latter, since the regions have the right to create new hospitals and merge existing ones. The Ministry of Health also has a right to supervise the hospitals in the interests of public health. Both the central and regional governments provide hospital funds, and these are allocated on the basis of the population of the area. The region also controls the organization, structure, and staffing in the hospitals.

231. FARNDALE, W. A. J. and RUSSELL, S. **Law on accidents to health service staff and volunteers.** (Case Studies on Law and Practice for Health Service Management (Vol. 7)). Beckenham, Ravenswood Publications, 1977, 72pp. £5.50

This book is intended for all employers and employees and especially hospital and health service staff, students, trade unions and hospital volunteers. It describes the law and practice relating to accidents at work, the rights of staff to claim damages and the consequent legal liability of employers and health service authorities to compensate their staff for such accidents. It shows the legal rights of staff injured at work to claim under the Industrial Injuries Scheme of the Social Security Act 1975 and also to claim common law damages based on a claim against the employer under the tort of negligence. It discusses the possible defences of the health authority faced with a claim by staff injured at work.

OTHER SPECIAL ASPECTS: COMMISSIONING, MOVING

See also Abstract No. 169

232. RUNDLE, M. **Commissioning today.** *Hospital Engineering*, London, 1977, Sept., vol. 31, no. 7, pp. 7-9.

In 1967 the then Ministry of Health published Hospital Technical Memorandum No. 17 [see *Hospital Abstracts*, Vol. 8, Abstract 359] dealing with the commissioning of hospital engineering installations. In 1974 the Department of Health and Social Security established a new working group consisting of engineers representing the Department, regional health authorities, consulting engineers, the Hospital Engineering Research Unit and contractors to review experience and developments since 1967. This paper summarizes the main points of the draft document which the group produced for circulation and indicates the current thinking on commissioning. It covers: principles and definitions; commissioning and the associated activities; and documentation. The new document differs from its predecessor by seeking to emphasize the creative role of the designer and to separate his responsibilities from those of the contractor and site staff who are involved in translating the design into an installation in accordance with the contract conditions. It also stresses the importance of the client's commissioning adviser and tries to set commissioning in the correct position in the sequence of events.

233. POTTER, D. G. **Handover - maintenance and operation.** *Hospital Engineering*, London, 1977, Sept., vol. 31, no. 7, pp. 9-13, 16-19.

There is a distinct change in considerations at the handover stage of a new hospital. It has to be considered that the hospital is being put into immediate use to meet an ongoing medical need. The points discussed in this paper are: primary function of a new hospital works department; information required and its service; timing of related activities; presentation of information; preparation by the works department for handover; and client staff (works department) training. It is suggested that attention be focussed on setting up the new works department's establishment to meet the engineering needs of the hospital. Senior staff should be in post and located on the site, at some sensible period before handover. Their success is dependent upon the documentation associated with the project being released in advance of handover. The whole pre-handover preparation should culminate in a formal training session.

FINANCE AND ACCOUNTING

See Abstract No. 213

FINANCE

See also Abstract Nos. 214, 217

234. Gezondheidszorg in Nederland: financeel-economische analyse van het ziekenhuis (IV). **[Health care in the Netherlands Part IV: a financial and economic analysis of the hospital service.]** *Instelling-Management*, Amsterdam, 1977, Aug. 24, vol. 9, no. 8, pp. 6-8.

The article (fourth in a series) discusses various ways of hospital financing: (i) overdraft on current account—mainly a short-term measure to deal with liquidity

fluctuations, sometimes backed up by a loan, and at present much in demand because of belated Government approval of new hospital fees and salary legislation; (ii) supplier's credit—fairly expensive and use of alternative forms of credit is recommended; (iii) debenture loans—these offer high interest rates to investors, are usually long-term, small, with little scope for negotiation of terms and mainly used for financing of building programmes; (iv) private contract loans—long-term, not publicly issued, provided by a limited number of investors (usually large companies), and conditions can be negotiated; (v) medium-term bank loans—these are for fixed periods (average two-to-10 years), can be taken up in stages, are normally Government guaranteed and mostly used for purchase of supplies; (vi) finance leasing—a form of financing purchase of goods enabling their immediate use without capital expenditure. Terms can be negotiated, and it is mostly used for purchase of equipment. Hospital borrowing requires certain sureties, i.e. cession of debtors, mortgage, Government guarantees. More details are discussed and the paper includes two illustrating tables on receipts, expenses and building costs of various types of hospital.

235. BICE, T. W. and SALKEVER, D. S. **Certificate-of-need programs: cure or cause of inflated costs?** *Hospital Progress*, St. Louis, 1977, vol. 58, no. 7, pp. 65-67, 100.

Some of the background to certificate-of-need (CON) controls of hospital investment in the United States is presented. The results of an analysis of the effectiveness of CON programmes in controlling health care costs in 23 states and the District of Columbia between 1968 and 1972 are outlined and discussed. They indicate that CON regulation did not control hospital cost inflation between 1968 and 1972 and may have brought about higher per capita costs. CON controls did not affect total hospital investment, but altered its composition. The net effect was to cancel cost savings that might have resulted from control over expansion of hospital beds.

236. REICHERTZ, P. L. and others. **Cost and spectrum of intensity of medical practice in a tertiary care environment.** *Medical Informatics*, London, 1976, Dec. 4, vol. 1, no. 4, pp. 269-284.

The paper describes results obtained with an integrated hospital information system with regard to the survey of services rendered in the hospital and costs generated in the various divisions and clinical services. A substantial drop in drug expenditures could be achieved by appropriate information dissemination and valuable data obtained on the organization of cost within a tertiary care centre. General conclusions are drawn from these observations.

237. BOWLER, M. K. and others. **The political economy of national health insurance.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1977, vol. 2, no. 1, pp. 100-133.

There is increasing pressure in the United States for a national health insurance scheme, but many physicians, hospitals and insurance companies prefer the present system, arguing that the market structure of American medicine is responsible for the high quality of care. The arguments on both sides have been speeded up by the general belief that American medicine is in a critical state. Proposals for three different types of national health care dominate the public debate: (i) minimal intervention

measures, offering minimum public control but allowing the Government to redistribute costs; (ii) major Government action, proposing a Government monopoly of health insurance; and (iii) a mixed strategy of increased Government regulation and a partial federal subsidy of the present system. Details are given of plans which fall into one or other of these categories. The proposals do not allow for the rate of inflation in medical care prices, but a system of complete federal financing has the best chance of keeping costs down. A national health insurance scheme would probably achieve a better distribution of services, but is unlikely to improve the quality of care, except possibly in the field of preventive medicine. The return of a democratic majority in the 95th Congress has enhanced the possibility of an expansion of the federal Government's responsibility for health care, but given the current ideological differences and pressures on the federal budget, a full national health insurance scheme is unlikely to come about for some time.

SUPPLIES AND STORES

SUPPLIES

238. HOUSLEY, C. **A job description for the materiel manager.** *Dimensions in Health Service*, Toronto, 1977, Aug., vol. 54, no. 8, pp. 24-26.

The article outlines a job description for a materials manager, whose duty is to control supplies from acquisition to distribution. He should be responsible for: (i) the purchasing agent; (ii) the chief pharmacist; (iii) the central sterile supply supervisor; and (iv) the central stores supervisor. Supervision of the materials manager will vary according to the stage reached in total materials management in any one hospital. The materials manager, or his representative, should be a member of at least the following hospital committees: (i) standardization; (ii) pharmacy and therapeutics; (iii) patient care audit; and (iv) cost containment. The candidate for the post should have at least three years' experience in materials management and should possess fundamental management and communication skills. His other duties should include: (i) negotiating with suppliers; (ii) holding regular departmental meetings; and (iii) preparing an annual departmental budget. Every manager should be evaluated regularly and receive a salary appropriate to his education, training and responsibilities.

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See also Abstract No. 253

239. MAGGI, R. and SCARPINI, F. Il monouso. **[Disposables.]** *Tecnica Ospedaliera*, Roma, 1977, June, vol. 7, no. 6, pp. 42-47.

With the help of four tables, the authors analyse the cost of providing, washing, drying, and replacing conventional glass test tubes in four hospitals and show that disposable test tubes cost less. It is also cheaper to purchase disposable test tubes which already contain anticoagulant than to add anticoagulant to conventional test tubes. The cost of storing the disposables is less than that of tying up capital in the stock of glass tubes.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

240. Het Nieuwe Spittaal te Warnsveld: met behulp van magnetrontunnel worden dagelijks 530 maaltijden geregenereerd. **[At the New Hospital in Warnsveld, 530 (frozen food) meals are reconstituted with the help of a magnetron tunnel.]** *Voeding-en Huishoudgids*, Amsterdam, 1977, July 25, vol. 44, no. 535, pp. 368-370.

The hospital employs the Swedish Finessa food distribution system whereby food preparation is separated from food distribution. Prepared food is cooked in Gastronom standard containers which are then conveyed on trolleys to a portioning belt where the food is portioned into three-sectioned dishes, covered with hoods of synthetic material, stacked on to container trolleys, cooled and stored at 3°C. Re-heating is carried out in a Kreiss Electronic 3000 megnetron tunnel (nine elements) which runs alongside a food distribution belt carrying trays laid with patients' coded diet cards, cold dishes, etc. At the end of the tunnel the re-heated dishes receive a boost of infra-red heat to prevent loss in transit, are placed on pre-heated underplates and their hoods are replaced by hoods of rust-free steel. Certain foods, such as offal and beans, are not suitable for magnetronic re-heating and there is always some loss of flavour. The 21 catering staff work in shifts during weekdays preparing cooked meals in advance and cold dishes daily. During weekends eight staff are employed. The staff restaurant, also used by visitors, has five self-service magnetron ovens. Restaurant, polyclinic and patients' day-room have slot machines with snacks and beverages. The paper includes seven photographs, a ground plan of the kitchen and an example of a menu card.

DIETETICS IN THE HOSPITAL

241. ALLEN, R. J. **Dietitians Board colloquium on 'dietitians of the future'.** *Journal of Human Nutrition*, London, 1977, Aug., vol. 31, no. 4, pp. 273-299.

In November 1976 the Dietitians Board held a colloquium to stimulate discussion and critical evaluation of the report of its working party on the future role of dietitians. The colloquium was attended not only by dietitians with a wide variety of interests, but more especially people from many fields of activity in which dietitians are or may be involved now or in the future. The texts of the formal papers given at the colloquium and a summary of the ensuing discussions are presented. The titles of the papers are: dietitians and medicine; the views of the profession; dietitians, the Department of Health and Social Security and the National Health Service; dietetics in the world scene; dietetics in Europe—particularly in the EEC; and dietitians and catering.

242. Diëten 1: Gezondheidszorg is een dure zaak, maar falende dieettherapieën kosten nog meer: voedingswaardedeclaratie op produkten zeer gewenst. **[Diets 1: health care is expensive but faulty diet therapy costs even more: food value labels on products are much to be desired.]** *Voeding-en Huishoudgids*, Amsterdam, 1977, July 25, vol. 44, no. 535, pp. 374-376.

Hospital diets, both normal and special, are usually 'standard' for everybody.

The paper suggests that they should be adapted to the feeding patterns and preferences of the individual patients, thus saving waste in food and therapy. A normal diet contains a daily average of sufficient nutrients, but the quantities required will vary individually according to body weight, age, sex, level of activity. In special diets one or more nutrients are reduced, added or eliminated and the food consistency may vary. Quantities are calculated per day. Description of diets by physicians is at present arbitrary according to diagnosis, aim, and even name of inventor. Standardization is called for with clear diet instructions for patients, doctors and dietitians. The latter should advise patients on how to compose their diets which includes information on amount of nutrients. The introduction of a 'food value label' stating on products their nutritional value in units as used by the consumer (e.g. grams of protein per slice of bread) is suggested. This is also recommended for cookery books, convenience foods and packed prepared dietary foods. Patients can then work out their diets each day whether inside or outside the hospital. The paper includes a diagram on various types of diets.

243. MANNARELLI, C. L'evolizione organizzativa, strutturale ed operativa nei servizi dietetici ospedalieri. **[Organizational, structural and operational development in hospital dietetic services.]** *Tecnica & Metodologia Economale*, Firenze, 1977, July/Aug., vol. 16, no. 4, pp. 224-236.

The author examines each of five factors which may affect the basic parameters in hospital dietetic departments in the next 25 years. These are: changes in dietary treatment; the relationship between the availability and consumption of types of food nationally and internationally; the relationship between demographic changes and regional and national health policy; the development of industrial food technology; and technical advances in the construction and transport of dietetic department equipment. He has interesting observations to make on the changes in Italian eating habits over the past 20 years. The most important factors, in his opinion, may well be the widespread use of pre-cooked frozen individual meals and the development of special trolleys to transfer these speedily from the kitchen to the patient without heat loss.

244. WADE, J. E. **Role of a clinical dietitian specialist on a nutrition support service.** *Journal of the American Dietetic Association*, Chicago, 1977, Feb., vol. 70, no. 2, pp. 185-189.

The functions of the Nutrition Support Service at New England Deaconess Hospital, Boston, are nutritional therapy, education and research. A clinical dietitian specialist is actively involved in the multidisciplinary team which staffs the service. The dietitian assists in the nutritional assessment of patients and is responsible for determining the enteral formula which will most effectively meet each patients' needs.

245. Diëten II: elke patiënt kan een individueel dieet krijgen, aangepast aan zijn behoefte: problemen zijn uitsluitend organisatorisch. **[Diets II: each patient can ask for an individual diet suited to his needs: the problems are exclusively organizational.]** *Voeding- en Huishoudgids*, Amsterdam, 1977, Sept. 19, vol. 44, no. 537, pp. 471, 473.

The paper (second of two articles, see Abstract No. 242) discusses how to advise

patients on their prescribed diets. A dietitian should first enquire into the patient's feeding pattern, i.e. what his meals usually consist of. The terms 'bread', 'meat', etc. are collective names for groups of foods with similar functions in the building up of the menu. The diet advice is then built up on diet prescription and feeding pattern. An example is given of a low-protein diet. The patient is informed of the nutritional value and protein content of various foods per distribution unit (e.g. protein per slice of bread or ham). The effects of various ways of preparation, the existence of ready-prepared low-protein foods and the use of low-protein substitute foods are pointed out. The amounts allowed are worked out over the number of meals per day, and this provides scope for variety. An example is printed of a diet advice form with figures indicating amounts and types of food. A patient provided with this list which gives comparable values of various food units can make his own alterations. Diet advice is given in polyclinics and other fields of extra-mural health care. Its introduction into hospitals and other health institutions is only a matter of organization. Standardization is recommended.

KITCHENS

246. Nieuwe grootkeuken Verpleeg-en Verzorgingshuis Elisabeth te Breda. Werken in haast erbarmelijke omstandigheden heeft teamverband versterkt. Problemen rondom bouwvergunning zorgden voor stagnatie niewbouw. **[The new central kitchen at the Elisabeth Hospital and Nursing Home, Breda. Teamwork helped to cope with work done in poor circumstances. Building licence problems caused reconstruction delays.]** *Voedigg- en Huishoudgids*, Amsterdam, 1977, Sept. 19, vol. 44, no. 537, pp. 458-461, 463, 465, 467, 469.

During re-building (with the kitchen temporarily in a tent) a working team worked out a food distribution method based on plentiful supply, tasty meals (conventional cooking), choice of menu and portioning coupled to distribution. Types of diets were coded one to 20 plus numbers for special diets; menu cards were coded A and B plus letters for special requests. White and green forms for warm and cold meals respectively were issued to patients to fill in their choices. These were transferred by the administration to specially designed basic cards in four code colours with coloured stickers for various dishes. The cards were passed on to the kitchen where a staff of 25, working varying shifts, caters daily for 500 meals. The 'Praktinorm' distribution system is employed whereby meals are portioned in the central kitchen onto three-sectioned dishes, covered by rust-free lids, kept warm on pellet-heated underplates and placed on trolleys with sunk-in tops to prevent sliding during transport by bus to the buildings and by lifts to the departments. More administrative details are given including ordering kitchen supplies, staff occupation and working hours, and an enumeration of kitchen equipment. The paper gives 15 pictures, a ground plan of the kitchen and examples of two weekly menus and three menu cards.

CANTEENS, STAFF DINING-ROOMS

247. Bloedtransfusiedienst te Amsterdam: grote kantine met 270 zitplaatsen tijdelijk ondergebracht in noodgebouw; uitgiftebalie met losse segmenten blijft, bruikbaar. **[The Amsterdam blood transfusion service's large 270-seater staff canteen is temporarily housed in an emergency building: immovable exit railings**

made of loose segments are a useful part of its equipment.] *Voeding- en Huishoudgids*, Amsterdam, 1977, July 25, vol. 44, no. 535, pp. 371-373.

The Zanussis system provided by Berkel Marynen BV, Culemborg, for the installation of a temporary canteen for more than a thousand staff, was chosen because its food distribution counter consisted of loose units which could easily be re-arranged and assembled when moving to the new premises to be built in due course. Behind the counter is an open kitchen equipped with a six-burner oven, double frying range, steam cooker, hot plate, 150-litre cooking kettle, hot air oven to keep 30 meals hot and a small magnetron oven. A large store-room, a cold store and a deep-freeze cell are used for storage. The counter has a tray-rail with crockery holder, units for stacked dishes and plates, units for keeping food warm or cool and a cash register unit. A coffee maker is placed separately from the counter to ensure smooth flow of serving. The washing-up section is near the exit and on leaving, used trays can be passed through a hatch. This layout avoids much cross traffic. Coffee and tea are provided during the morning, coffee and snacks at lunchtime and warm meals between 4.30 and 5.30 p.m. Every charge is a standard five guilders (approx. £1.20) and instead of change a credit note is returned. The paper includes nine pictures and a ground plan of the canteen.

HYGIENE IN THE HOSPITAL KITCHEN

See Abstract No. 255

LAUNDRIES AND LINEN SERVICE

HOSPITAL LINEN AND TEXTILES

See Abstract No. 250

HOSPITAL DOMESTIC MANAGEMENT

248. LONG, D. **Problems of keeping an old hospital as good as new.** *Health and Social Service Journal*, London, 1977, Sept. 9, vol. 87, no. 4557, pp. 1284-1285.

Old buildings, like the Northampton General Hospital, built in 1793, are very difficult to keep clean. Atmospheric pollution, an open cage lift and continuous building maintenance make dust control a never-ending process. Vacuuming is supplemented by damp dusting and the use of the Forshaga dust control system. As there are about 16 different types of flooring in the hospital, the domestic services manager has an enormous task maintaining them using a wide variety of efficient cleaning agents, seals and dressings. All floors, except those which are worn and porous, are at present being spray cleaned with an alkaline detergent, Tri-Chem GPK, and the wood floors are being cleaned, sanded, and coated with a laminated plastic seal. Vacuuming of carpets is supplemented by regular cleaning with a hot water extraction machine. The hospital plans to investigate the possible use of equipped and trained mobile teams, to carry out internal and external cleaning on a district basis.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

249. FALKINER, F. R. and others. **Cross infection in a surgical ward caused by *Pseudomonas aeruginosa* with transferable resistance to gentamicin and tobramycin.** *Journal of Clinical Pathology*, London, 1977, Aug., vol. 30, no. 8, pp. 731-737.

An outbreak of gentamicin- and tobramycin-resistant *Pseudomonas aeruginosa* infection occurred in a surgical ward over a three-month period. Resistant *Ps. aeruginosa* strains with the same serological, phage and pyocin type were cultured from the urine of six patients. Identical organisms were found on urine bottles, bedpans and the hands of attendant staff. Inadequate disinfection played a major role in cross-infection. Isolates of the epidemic strain from each of the patients and of an unrelated but similarly resistant *Ps. aeruginosa* from one of them could transfer resistance to a recipient strain of *Ps. aeruginosa*. Resistance to gentamicin, kanamycin, tobramycin, sulphonamides, and mercuric chloride was determined by R factors belonging to Pseudomonas incompatibility group p-3. Aminoglycoside resistance was due to acetylation.

SOURCES OF INFECTION

See Abstract Nos. 249, 250

PREVENTION AND CONTROL

See also Abstract Nos. 177, 249

250. ELHAG, K. M., BAIRD, R. M. and SHAW, E. J. **Water beds—a potential source of *Pseudomonas aeruginosa*.** *Journal of Hygiene*, London, 1977, Aug., vol. 79, no. 1, pp. 103-106.

St. Bartholomew's Hospital, London, has five water beds, which are maintained at a temperature of 37°C when in use. Beds are stored empty in stores or in a side room and transported to a ward when the need arises. Before the investigation reported here there was no regular change of water or addition of disinfectant. At the start of the study three beds were in widely separated wards and two in storage empty. A sterile 50 ml syringe was used to withdraw 100ml of water from each bed. *Pseudomonas aeruginosa* was isolated in pure culture from each of the three beds initially examined, with bacterial counts ranging from 10^6 to 10^7 organisms/ml. At the same time *Ps. aeruginosa* was also recovered from swabs of bedsores taken from all three patients on the water beds and from a urine specimen from one of the patients. After the addition of sodium hypochlorite, giving a final concentration of 200 parts/10^6 available chlorine, to each of the water beds, no micro-organisms were recovered from any water sample during a six-month period.

251. LAFORCE, F. M. and EICKHOFF, T. C. **The role of infection in critical care.** *Anesthesiology*, Philadelphia, 1977, Aug., vol. 47, no. 2, pp. 195-202.

This paper reviews the three major categories of infection seen in critical care units: bacteraemia, lower respiratory tract infection and urinary tract infection. The aspects

covered for each are pathogenesis, epidemiology and prevention. A list of 47 references to the literature is included.

HYGIENE IN THE OPERATING THEATRE

252. HOET, T. Les impératifs de l'hygiène dans l'aménagement du quartier opératoire. **[Hygiene requirements necessary when equipping an operating theatre.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Aug./Sept., vol. 32, no. 383/384, pp. 51-60, 65-71.

This is a very readable account, illustrated by 19 clear diagrams, of the various methods which can be used to reduce the level of infection in the theatre block. The author first describes what he terms the 'customs posts' or entrances to the theatre block for patients, staff and material. He then deals with methods designed to reduce or eliminate contamination of the air within the block: ventilation, air conditioning, laminar flux (both horizontal and vertical, with an analysis of their advantages and disadvantages), and 'glasshouses'—the Charnley cell, the Weber cell, the Allander ceiling, and the surgical bubble. Finally he describes British, Swedish, German and French designers' approaches to the separation of septic and aseptic zones within the block.

STERILIZATION

253. SAMUELS, T. M. **Potential hazard in preloaded disposable Foley catheter syringes sterilized by ethylene oxide.** *Hospital Topics*, Sarasota, 1977, July/Aug., vol. 55, no. 4, pp. 35-36.

There is considerable data available on the time required to aerate a variety of materials after sterilization with ethylene oxide. But another problem which could be equally serious may have been overlooked; it is possible for this highly reactive gas to react chemically with some of the components of the disposable kits, resulting in the formation of new and potentially toxic products totally unrelated to degassing and not readily apparent to the user. Analysis of the solution in the syringe packaged with sterile Foley catheters confirmed the fact that ethylene oxide had reacted with the water to produce, at least, an ethylene glycol-water mixture and other reaction products could be present. While the exact clinical significance of this find is not known, it suggests a potential hazard if the retention balloon should break when in place in the bladder. It is recommended that: (i) staff should be informed that certain kits containing a prefilled syringe which may have been subjected to ethylene oxide sterilization may in fact contain toxic ethylene glycol; (ii) staff should carefully scrutinize commercially available sterile disposable products that have been subjected to ethylene oxide for possible toxic reaction products; (iii) standards should be developed for permissible limits of ethylene oxide reaction by products; and (iv) central sterile service staff should be made aware of this potential reaction and use caution or avoid sterilizing material within the hospital.

254. NYSTRÖM, B. **Differences between sterilization at hospitals and in industry.** In: Sterilization methods in industry, from: Skandinaviska studiedagar i sjukhushygien, Göteborg, 24-25 October, 1974, edited by Bengt Danielsson, pp. 72-77. Uppsala,

Almqvist and Wiksell, 1975, 84pp. *Acta Pharmaceutica Suecica*, vol. 12, supplementum, 1975.

The differences between sterilization methods in hospitals and industry are outlined. Industry sterilizes disposables; hospitals sterilize mainly used, non-disposable material. In modern automated central sterilization departments the cleaning and drying procedures may dessicate micro-organisms, but dessicated micro-organisms have a high resistance to ethylene oxide. An ethylene oxide sterilization procedure for non-disposable instruments in a hospital must kill dessicated micro-organisms with a high degree of safety. Toxic residue of ethylene oxide and its degradation products are removed from sterilized disposables by long quarantine storage at the manufacturers. For expensive heat-sensitive instruments at the hospital such a long period of quarantine storage gives unrealistically long circulation times. A more suitable alternative to the sterilization of heat sensitive non-disposable instruments in hospitals appears to be sterilization with low temperature steam and gaseous formaldehyde. For instruments that are too sensitive for this process only sterilization in buffered glutaraldehyde appears practicable.

INSECT AND PEST CONTROL

255. KAY, A. **Conducting a blitz against the cockroach and friends.** *Health and Social Service Journal*, London, 1977, Sept. 9, vol. 87, no. 4557, pp. 1288-1289.

The only effective means of preventing cross-contamination in areas where food is prepared is to ensure that all parts and surfaces which come into contact with food are washed with hot water and detergent, rinsed and disinfected. Dirty kitchens encourage mice, rats and cockroaches and the pest problem in certain built-up areas is increasing. Cleaning schedules should deal with each area and piece of equipment to be cleaned, and state the method and frequency of cleaning. In hospitals, attention must also be given to wards, ward kitchens, nurses' homes and corridors. Walls, floors and fittings of bathrooms and toilets must be washed and disinfected daily. Sluice rooms and laundries need special attention and refuse collection areas must be swept, hosed and kept tidy. Staff should be trained in the use of cleaning chemicals and wear protective clothing where appropriate. Mop-heads should be washed, boiled and soaked in disinfectant, swabs should be disposable and other cleaning implements should be washed regularly.

SAFETY MEASURES

ACCIDENTS, GENERALLY

See Abstract No. 280

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

See Abstract No. 253

PLANNING FOR MASS EMERGENCIES

256. JIMÉNEZ, L. S. Planificacion de los servicios de salud en situaciones de emergencia. **[Planning emergency health services.]** *Boletin de la Oficina Sanitaria Panamericana*, Washington, 1977, Feb., vol. 82, no. 2, pp. 98-111.

The planning of emergency health services in times of disaster involves an analysis of the resources that can be used, together with an assessment of the current situation and those that may develop. The sectional health plan should be taken as the frame of reference in preparing emergency plans for a region within a country, and should include general guidelines to be followed by each hospital in the region in working out its particular plan. The health sector should assume responsibility for: preparation of emergency health plans; first aid and emergency medical care; movement of the sick and wounded; organization of evacuee reception centres at hospitals; restoration of normal medical services; epidemiological surveillance and sanitation measures; help for the mental health services; and evaluation of action taken. Emphasis is laid on the fact that health sector activities, though important, are but one of the many fields of activity in dealing with emergency situations; their effectiveness will therefore depend largely on co-ordination with those other fields.

257. SEAVER, D. J. **Coping with internal disaster is a hospital priority.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 167-168, 170, 172.

Internal disasters, such as work slowdowns, major mechanical failures, explosions, bomb threats or staff shortages, are more likely to occur than external disasters or fires. Hospitals should therefore plan and practise for these eventualities as well as for external disasters and fires. The essential differences between internal and external disasters are outlined. Four principles should form the basis for the plan: (i) the particulars of the disaster must be identified; (ii) it is necessary for everyone to have certain basic information about the hospital; (iii) it is vital to define a clear and practical priority for communications; and (iv) each person's authority to act must be identified and understood. Details are given of the approach used at Methodist Hospital of Indiana, Indianapolis, to prepare an internal disaster plan, organize practice disaster drills and review their results.

RADIATION HAZARDS

258. INTERNATIONAL COMMISSION ON RADIOLOGICAL PROTECTION. **The handling, storage, use and disposal of unsealed radionuclides in hospitals and medical research establishments: a report of Committees 3 and 4 of the International Commission on Radiological Protection.** (ICRP Publication 25) Oxford, Pergamon Press, 1977, vi, 46pp. Annals of the ICRP, 1977, vol. 1, no. 2.

This replaces a previous publication of the International Commission on Radiological Protection and is primarily directed towards the competent national authorities. This report is concerned with the problems which arise owing to the use of unsealed radioactive substances in therapy, diagnosis and research. The areas considered include: hazards associated with radioactive sources and procedures; protection facilities; organization and responsibility; working techniques and protection of workers; protection of the patient; protection of individual members of the public; medical

research; control of radioactive contamination; monitoring; radioactive waste; emergency procedures; storage and transport of radioactive materials; and leakage from sealed and plated radioactive sources. Three appendices are included.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract No. 308

259. MacCulloch, M. J. **Some problems of placing psychiatric patients.** *Health Trends*, London, 1977, Aug., vol. 9, no. 3, pp. 59-62.

Psychiatric patients who are violent present increasing problems within conventional National Health Service psychiatric hospitals. Such patients are often the cause of conflict between lawyers and psychiatrists. The admission to Special Hospitals under the Mental Health Act of 1959 of patients who had committed no offence, and the increased use of psychotropic drugs has resulted in a decrease in detained patients and a lessening of physical security in psychiatric hospitals. However, some psychotic patients will inevitably become violent from time to time and hospitals often lack the staff and facilities to deal with them. Intermediate degrees of security, providing rehabilitation, are needed for some offenders and non-offenders alike and these could be provided within limited areas of NHS psychiatric hospitals. In July 1974, the Department of Health and Social Security asked the Regional Health Authorities to establish such units, but little progress was made. In February 1976, the DHSS agreed to finance the units centrally, aiming for all regions to have units in operation by 1980.

WELFARE OF THE PATIENT

See also Abstract Nos. 157, 259, 265, 266, 274, 293, 306, 313

260. MacKinnon, H. A. **Translators, telephone system expedite bilingual services.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 101-102.

In 1974, the 1,250-bed Jackson Memorial Hospital, Miami, Fla., established a programme to meet the needs of non-English speaking patients and relatives. It comprises a central pool of translators speaking Spanish and French, a corps of volunteer translators speaking other languages, and a telephone system. Three translators are on duty from 0800 to 1630 Monday to Friday, two from 0830 to 1630 Saturday and Sunday, two on the evening shift and one on the night shift. The average daily number of requests received by the service is 125. The telephone system enables three-way calls (physician or nurse, patient and translator) to be made. The cost of the programme is about $120,000 per year.

261. Belson, P. **The pattern of visiting today.** *NAWCH News*, London, 1977, vol. 1, no. 2, pp. 3-5.

Almost one-fifth of all hospital wards for children now allow 24-hour visiting, and

a further third allow parents to be present during day-time hours. One-sixth still have less than six hours visiting and a small number less than three hours, the amount of visiting varying according to the type of care required. Some accommodation for parents can be provided in two-thirds of the wards while one-sixth have such accommodation but limit its use. Children can now be visited on the day of operation, both before and after, in almost three-quarters of all wards offering general surgical care, but only in two-fifths of them in respect of ear, nose and throat children. Many children's wards restrict access for visitors during the lunch-hour and some do not allow visiting at all during school hours, even for quite young children. Five tables of details of the survey covering 800 children's wards are included.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 231

HOSPITAL SOCIAL WORK

See Abstract No. 308

TRANSPORT OF PATIENTS

See also Abstract Nos. 287, 288, 292

262. FORSTER, F. **Hospital transport for rural patients.** *Health Bulletin*, Edinburgh, 1977, Sept., vol. 35, no. 5, pp. 259-265.

Between April and June 1972, 1,342 patient journeys to and from the acute hospital at Peel, near Galashiels, eight cottage hospitals and their associated out-patient clinics were studied. Information recorded covered routine patient details, transport used and a medical assessment of each patient's suitability for different types of transport. The results, presented in six tables and discussed, cover: transport use; need for transport on medical grounds; provision of transport through the ambulance service; and alternative methods of travel for out-patients' journeys. The discussion emphasizes the difficulties to be faced in devising convenient and economically sound solutions to the travel problems facing rural hospital patients. The role that the ambulance services should play is not clear; the position of the hospital car service is enigmatic; there is uncertainty about the nature of transport innovations that may emerge from the policy discussions; and the effects of rising costs on car ownership and use are still obscure. Resolution of these issues, however, is a prerequisite to sound planning.

HOSPITAL CARE

See also Abstract Nos. 178, 185, 206-208, 251, 272, 284, 296-299, 302-304

263. OVERTON, P., HARRISON, F. and STINSON, S. **Patient classification by types of care.** *Dimensions in Health Service*, Toronto, 1977, Aug., vol. 54, no. 8, pp. 27-30.

Systems of patient classification by type, rather than level, of care are a relatively new development and involve the community health services as well as hospital

nursing care. Within the types of care patients will require different levels, so the two classification systems are related. Classification by type has been stimulated by the following factors: (i) the increase in the range of community health services; (ii) the increasing elderly population; (iii) the attention given to increasing health care costs in Canada; and (iv) the need to monitor existing health services and plan for the future. Information provided by patient classification by type may be used by a variety of persons and agencies at different levels of the health care system. Such information may be used for: (i) planning by individual institutions or, more broadly, at a regional or provincial level; (ii) assessing individual patient's needs; and (iii) improving the quality of care by indicating where patients are misplaced.

264. RANTZ, M. J. and COURTIAL, D. **Lifting, moving and transferring patients: a manual.** St. Louis, Mosby, 1977, viii, 138pp. £5.60

This is a guide to teach health care staff who carry out bedside care the safest and easiest methods of patient handling and transfer, and is intended for use by all those who move and transfer patients in institutions or homes. Specific directions for lifting and moving patients in frequently encountered situations are the focus of the text, and the techniques are illustrated by many photographs. A glossary and index are included.

265. BARTON, A. A. **Prevention of pressure sores.** *Nursing Times*, London, 1977, Oct. 13, vol. 73, no. 41, pp. 1593-1595.

This article provides a re-appraisal of pressure area care, and shows how many of the new techniques used in the treatment and prevention of pressure sores have been developed from recent advances in military and space medicine. The pathogenesis of pressure sores is examined and the main factors causing the condition are discussed including damage due to pressure, disruptive damage and vascular factors. In addition some of the products currently available to treat or prevent pressure sores are mentioned. The recent development of ACTH in gelatin solvent as a drug-based method of prevention is described. It has been found that this preventive measure is particularly effective when pressure sores are caused by disruptive damage, and some of the research findings illustrating this are discussed.

266. BICE, M. K. **Is the right to die a solo decision?** *Hospital Medical Staff*, Chicago, 1977, July, vol. 6, no. 7, pp. 1-7.

The question whether a patient has the right to choose life or death raises many issues. The legal and moral rights of the patient are not always the same and, in the United States, the legal rights vary from State to State. It is important to distinguish between the right to die and the right to refuse treatment. Competent adult patients may do the latter, but certain groups do not have this right: (i) prisoners; (ii) patients with dependents; and (iii) pregnant women. Patients legally incompetent include minors and adults whose understanding is impaired by illness. A guardian may not refuse treatment essential to life, but in other cases, acceptance of the refusal depends upon it being reasonable. The most difficult legal decision is whether treatment postponing death can be refused by a guardian, and the court's decision in the Quinlan case may be seen as a triumph of the patient's representative to refuse such treatment. The moral rights of the patient must also be considered. The case history

is described of a patient, judged to be competent, but wishing to die, a situation which involves, among other things, the doctor's moral requirement to preserve life. A depressed patient may not be the best person to judge how well his condition will respond to treatment. The new medical technology should be used to help the physician to preserve and restore the quality of human life, rather than to preserve it for its own sake.

267. STONE, D. **Professionalism and accountability: controlling health services in the United States and West Germany.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1977, vol. 2, no. 1, pp. 32-47.

The Professional Standards Review Organizations (PSRO) programme was created by the United States Congress in 1972 to impose cost and quality controls over medical services paid for by federal governments. The country is divided into 203 jurisdictions with PSRO's in 55 of them, and 65 conditional PSRO's. To ensure the compliance of doctors and hospitals, services not approved by a PSRO cannot receive federal funds or be reimbursed by Medicare or Medicaid for services provided. The Economic Monitoring System in West Germany works somewhat differently, but also imposes reviews of public sector services, carried out by organizations of physicians with a mandate from the federal government. The German system, which has been operating in some form for 40 years, has strengthened the organization of established medical bodies, allowing them to operate government health programmes as these were developed. In the United States, most PSRO's are a separate bureaucratic organization, but some existing organizations have been granted conditional PSRO contracts and, in addition, are allowed to act as insurers and sell medical service 'packages'. Both systems run the risk of becoming rigid. The German system is out-dated in its fee schedule, has developed fixed patterns of practice and tends to favour practical rather than advisory help to patients. The PSRO programme is a delegation of congressional authority to regulate a federally financed health service and Congress has failed to provide for future development of procedure and norms. Unless the findings of PSRO's are made available for public discussion, the system could have an adverse effect on innovation in medical practice.

268. LUCAS, R. W. **Clinical decision making 3. Questioning patients by computer: who will benefit?** *Health Bulletin*, Edinburgh, 1977, Sept., vol. 35, no. 5, pp. 296-302.

This paper concerns the use of computers in the clinical decision-making process, not for calculating decisions, but for collecting data about illness directly from the patients by questioning. Such data may subsequently be used in the calculation of decisions. The development of computer questioning of patients is outlined and three aspects of patient-computer interface are considered: presenting the questions; the method by which the patient answers the questions; and the questions themselves. The criteria by which computer interrogation is best evaluated are accuracy, acceptability to the patient, and monetary cost. In routine questioning, computer interrogation appears to be as accurate and as acceptable to patients as questioning by doctors, yet is potentially much cheaper. The effects, and particularly the benefits, of computer interrogation to the National Health Service, the doctor and the patient are discussed.

269. SOMERS, H. M. **The malpractice controversy and the quality of patient care.** *Milbank Memorial Fund Quarterly, Health and Society*, New York, 1977, vol. 55, no. 2, pp. 193-232.

In 1975 the United States had its first strikes by doctors, when they withheld their services, except for emergency cases, chiefly because of disputes over malpractice insurance. It must be recognized that the legal and cost problems will probably never be eliminated as long as torts and tort liability remain normal facts of life. It is the thesis of this paper that the problems will not be satisfactorily or equitably alleviated until they are effectively related to problems of quality care and the doctor-patient relationship in modern society. The aspects discussed are: insurance trends; premium costs: claims, awards and settlements; recent state legislation; steps towards prevention and control; and prevention, quality and patient relations. The malpractice situation is complex and multidimensional. Though there is much to be remedied, the crisis does provide an opportunity for dealing more effectively with the quality of care and introducing counter influences against the technological depersonalization of the health care process.

DISCHARGE OF PATIENTS

See Abstract No. 275

HOME CARE, AFTER-CARE

270. LEVY, E. C. and others. Experiencia de una unidad de atencion domiciliaria en Chile. **[Experience with a domiciliary treatment unit in Chile.]** *Boletín de la Sanitaria Panamericana*, Washington, 1977, Feb., vol. 82, no. 2, pp. 132-136.

In view of the demand for hospital beds in Chile, a 'controlled early discharge unit, was established in Santiago aimed at reducing length of stay in hospital and to help patients recuperate at home. A domiciliary treatment unit, staffed by physicians, nurses, nutritionists and social workers was set up with responsibility for evaluating the family's socio-economic position, and to assess the patient's progress once he had returned home. After one year statistics revealed that discharges were up by 62.5 per cent and the average hospital stay cut by 46.8 per cent, confirming the success of the scheme.

SPECIAL DEPARTMENTS

ANAESTHESIA

271. Speciale schakeling voor anesthesisten-oproep: moderne intercominstallatie in nieuwe Sint Franciscus Gasthuis te Rotterdam: direct onderling contact mogelijk. **[A special anaesthetist call linking system: modern intercom equipment in the St. Francis Hospital, Rotterdam, makes direct mutual contact possible.]** *Technische Gids*, Amsterdam, 1977, Aug. 8, vol. 46, no. 1125, pp. 417, 419.

The Philips M 100-system provides direct contact between the theatres, casualty department, day hospital, laboratories, psychiatric department, polyclinic and porter's

lodge. It is decentralized, entirely electronic and based on three main elements: intercom posts, guide unit (one per section of a maximum of 100 posts), and cableing. The posts can be connected at any connecting point and each post has its own number. A call is made by pressing a button, the 'duplex' working of the system ensuring direct conversation. Several posts can communicate simultaneously. The receiver flex extends to approximately five metres thus enabling callers to move about while speaking. It was found that the average intercom call lasted 30 seconds against two to three minutes for the external telephone. The system is also connected to the waiting hall's call installation which has a 'whisper' system with forty low-voice loud-speakers to ensure good reception without shouting. A special switch system is designed for calling anaesthetists in any of the eight theatre units. Calls come through in a low voice and a coloured light switches on with a different colour code for each anaesthetist. The system has at present 200 connections apart from the call installation and is designed for extension to 600 posts. The paper includes two pictures.

272. STEPHENS, D. S. B. and BOALER, J. **The nurse's role in immediate post-operative care.** *Nursing Mirror*, Sutton, 1977, Sept. 29, vol. 145, no. 13, pp. 20-22.

The aim of this survey was to establish nurses' knowledge of immediate post-operative care and the facilities for post-operative recovery in one region. The sample consisted of 163 randomly selected nurses (including State Registered Nurses, State Enrolled Nurses and learners) in one health district who were asked to complete a confidential questionnaire. The questionnaire was supplemented by an interview with one of the researchers. The resultant data was analysed using X^2 test with Yate's Correction of Fisher's exact test. A further 116 nurses (including some from other regions) were asked by questionnaire at which point in their training they were first asked to collect a patient from the operating theatre and whether they felt they were sufficiently experienced. Data about facilities were obtained from consultant anaesthetists resulting in information about 27 surgical units in the South East Thames Region. The survey indicated that nurses were competent to care for the unconscious patient as long as no complications arose and that nurses felt more confident in the stable atmosphere of the ward.

PHARMACY

See also Abstract No. 281

273. DAVIS, N. M., LARSON, R. and COHEN, M. R. **A pharmacy patient profile for inpatients in a unit dose system.** *Hospital Pharmacy*, Philadelphia, 1977, July, vol. 12, no. 7, pp. 332-334, 336, 338, 340-341.

The pharmacy patient profile is a record of drug orders and doses dispensed, and of clinical information about the patient recorded in a uniform format. The form used at the 500-bed Temple University Hospital, Philadelphia, was developed 10 years ago and has undergone 10 revisions, each revision reflecting the increased sophistication of the drug distribution system and of the clinical involvement of the pharmacist. The forms are kept in visible index files. Details of the procedures

followed are described and sample profiles are reproduced. The profile is the focal point of unit dose distribution, it enables the pharmacist to clinically monitor drug therapy and provides a record of doses administered for charging purpose.

274. SACKETT, D. L. and HAYNES, R. B., editors. **Compliance with therapeutic regimens.** Baltimore & London, Johns Hopkins University Press, 1976, xiv, 293pp. £12.00

This book is concerned with the extent to which the patient's behaviour (in terms of taking drugs, following diets or carrying out other changes in life-style) coincides with the clinical prescription. It is a development of the Workshop/Symposium on Compliance with Therapeutic Regimens, held at McMaster University Medical Centre, Hamilton, Ont., in May 1974. Aspects covered include: the magnitude, determinants and measurement of compliance; strategies for improving compliance; compliance and therapeutic trials; and recommendations for future research. An annotated bibliography with additional chapter references is included.

275. MACDONALD, E. T., MACDONALD, J. B. and PHOENIX, M. **Improving drug compliance after hospital discharge.** *British Medical Journal*, London, 1977, Sept. 3, vol. 2, pp. 618-621.

In a study discussed, 165 discharges from the department of geriatric medicine at Sherwood Hospital, Nottingham, were allocated to one of three groups. Sixty patients had their drug routine explained to them by the clinical pharmacist, another 45 were similarly counselled and also given either a pill wheel, a tear-off daily calendar or a tablet identification card as a memory aid. The remaining 60 patients were not given detailed counselling. Patients came to the hospital on the seventh day after discharge to have their drug compliance checked and then attended twice weekly, detailed reassessments being made at six and 12 weeks after discharge. Four types of error were assessed: (i) underdosage; (ii) overdosage; (iii) old medication; and (iv) other people's tablets. Multiple errors were much commoner in uncounselled patients; by 12 weeks these patients were making errors in 3.2 times as many categories as counselled patients. Counselling was still effective in mentally frail patients. The only memory aid which modestly improved compliance was the daily calendar. The pharmacist's initial assessment of how well the patient understood his counselling correlated with subsequent performance. A 15-minute talk to all elderly patients, however confused, is invaluable in reducing the risk of drug misuse. Detailed results of the study are shown in three tables.

276. PANG, F. J. **Seven-year review of the unit dose system in a private hospital.** *Hospital Pharmacy*, Philadelphia, 1977, July, vol. 12, no. 7, pp. 324-326, 329-330.

The 325-bed Porter Memorial Hospital, Denver, Colo., implemented a unit dose system in the summer of 1970 as a pilot project and extended it to the whole hospital in the summer of 1970. The pharmacy is staffed by a director, eight pharmacists, a part-time pharmacy intern, two messengers, a clerk and seven pharmacy technicians. A 24-hour service is provided for both in-patient and out-patients. A MacBick unit dose trolley with modified narcotic drawers is used. Details are given of controlled substances, procedures for nursing staff, procedures for pharmacy staff, trolley exchange schedule, and pricing and financial information. During seven years six

major changes in the system have taken place: (i) the medication administration record was revised; (ii) the pharmacy patient profile system was revised; (iii) a per diem pharmacy charge system was begun; (iv) a procedure was begun of mutual nurse-pharmacist checking of unit dose drawers; (v) the pharmacy messenger service was increased from every hour to every 30 minutes; and (vi) the nurses' drug reference book was made available to all medication nurses. The system has been accepted by physicians and nurses and has reduced the nursing time required for drug preparation, clerical work related to drugs and the incidence of drug administration errors.

LABORATORIES

277. El laboratorio en el hospital. [**The hospital laboratory.**] *Policlinica*, Barcelona, 1977, May/June, no. 39, pp. 11-14, 17-18.

This is a practical guide to the factors to be considered when planning a new hospital laboratory. These include the services which will be provided (haematology, biochemistry, microbiology, pathology), the volume of work anticipated in each service, the amount of equipment and number of staff required, and the number of rooms required in addition to the laboratories proper. Progress in laboratory techniques is now so rapid that allowance must be made for an annual increase in the volume of work carried out of at least 10 per cent. The guide includes six tables which supply useful information on the number of analyses per laboratory unit in hospitals of various sizes, the number of analyses per technique, the number of units required in relation to the size of the hospital, as well as a diagram showing the ground plan of the new laboratory at Perpignan.

278. MacGillavry, G. B. **A modular computer system for clinical laboratories.** *Medical Informatics*, London, 1976, Dec. 4, vol. 1, no. 4, pp. 257-268.

The use of central integrated data management external to the laboratory together with a decentralized data entry and input system has resulted in fewer administrative jobs at the laboratory reception centre and in the clinical laboratory itself. Terminals linked to the central management system of the Hôpital Universitaire Brugmann, Bruxelles, are located in various hospital departments for the positive identification of samples. The advantages of this system are its flexibility and complete integration with the control management system. There is now greater emphasis upon source data capture and local acquisition of data as a result of the installation of independent mini-systems.

BLOOD TRANSFUSION DEPARTMENT

See also Abstract No. 247

279. Biggio, B., Jouvenceaux, B. A. and Falcoz, H. **Information system for blood grouping of patients.** *Medical Informatics*, London, 1976, Dec. 4, vol. 1, no. 4, pp. 237-244.

The immuno-haematology laboratory of the Blood Transfusion Centre of the Edouard Herriot Hospital, Lyon, carried out 45,000 blood group tests in 1974. An

information system was established in 1976 to create a file of blood groups which can be maintained by manual or automatic methods. All laboratories in the Centre will have access to the system and the reference files of the patients. The laboratory possesses a terminal with a CII Iriscope 300 screen and a CII IS 180 printer linked to the central computer of the Lyon Civil Hospital. Information can be obtained on patients' identity and any previous blood group test. The computer prints out copies of the group card, detailing the tests carried out, and also produces the official copy for the laboratory, charges for the tests, and special activity statistics. As a result of this system safety in transfusions is improved and wasteful repetition of tests avoided.

280. LeBourdais, E. **Controlling transfusion errors.** *Dimensions in Health Service*, Toronto, 1977, Aug., vol. 54, no. 8, pp. 20, 22-23.

Errors or hazards may occur at various junctures in the blood transfusion process and may be fatal. They include the following: (i) no labelling, or incomplete labelling, on a patient's blood specimen tube; (ii) blood sample requisition form attached to the wrong tube; (iii) blood being given to the wrong patient; and (iv) no observation of the patient during the early stages of transfusion. Blood should be issued only on presentation of a written request which includes full details of the patient. A detection system is described whereby the specimen tube has stuck to it a label taken from the patient's wristband, which must correspond with the name and number already on the request slip and the tube. Of the 463 hospitals in Canada providing transfusion laboratory services in 1973, only 165 had blood transfusion committees, and 7,506 transfusion reactions occurred. A committee can have a significant impact on quality control and the Canadian Council on Hospital Accreditation recommends written policies and procedures for blood transfusion laboratories. Cases of all adverse reactions should be investigated promptly and the Canadian Red Cross estimate that the incidence of non-fatal reactions in Canada is about once every 5,000 to 10,000 units transfused.

RADIOISOTOPE DEPARTMENT

281. Cruz, P. M. and Winship, H. W. **The status of radiopharmacy as viewed by nuclear medicine department directors.** *Hospital Pharmacy*, 1977, July, vol. 12, no. 7, pp. 342-343, 346, 356.

Questionnaires were completed by 35 directors of nuclear medicine departments who did not employ radiopharmacists and by 15 directors of such departments who did employ radiopharmacists. The object was to determine the status of radiopharmacy as viewed by nuclear medicine department directors. The results are summarized in four tables and discussed. It is concluded that the employment of a radiopharmacist is hindered by the lack of information disseminated concerning his capabilities. The recommendations made should help to improve the status of radiopharmacists: (i) those departments who do not employ radiopharmacists should be informed about the services they can provide and the cost factors involved; (ii) all pharmacy schools providing radiopharmacy training should introduce, explain and communicate the expertise and availability of the radiopharmacist; and (iii) information should be directed not only toward those within the profession of pharmacy, but also to administrators and others.

REHABILITATION

See also Abstract Nos. 306, 307

282. GRAHAME, R. **Guy's Hospital rehabilitation services.** *Newsletter, Demonstration Centres in Rehabilitation*, Middlesbrough, 1977, July, no. 9, pp. 3-5.

The use of the rehabilitation services at Guy's Hospital, London, is shared amongst many departments, but the largest case load as well as some of the responsibility for organization falls on the department of rheumatology, which caters for patients with a wide variety of locomotor disorders. Out-patient clinics are provided at Guy's Hospital, New Cross Hospital and St. Olave's Hospital. In addition to general clinics, there are special clinics for sports injuries, ballet dancers, staff, gold/penicillamine treatment, gout and back pain. In-patient facilities comprise 50 beds at New Cross Hospital plus additional beds at Guy's and St. Olave's. The facilities available are outlined, together with the teaching and research programmes, and relationships with other departments.

PHYSIOTHERAPY DEPARTMENT

See Abstract No. 282

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 314

283. CULLINANE, J. S. **Alcoholism facility separate but allied to medical center.** *Hospital Progress*, St. Louis, 1977, Aug., vol. 58, no. 8, pp. 76-79.

Hyland Center is an 80-bed facility for the treatment of alcoholism on the site of St. Anthony's Medical Center, St. Louis. The single-storey, lodge-type building cost $4.5 million. The centre is equipped with examination rooms and two nursing stations, a spacious dining-room, library and lounges. Average length of stay has been 22 to 23 days. In a 12-week after-care programme, the patient and his family are involved in counselling sessions that focus on correcting emotional damage. The heads of the six departments within the centre (medical, nursing, counselling, dietary, business office and building services) meet the director four or five times a month in a spirit of what is seen as participatory management. Occupancy is only 55 per cent but is expected to increase through education.

INTENSIVE CARE UNITS

See also Abstract Nos. 188, 251

284. PORTER, S. W. **Intensive therapy nursing.** *Intensive Care Medicine*, Berlin, 1977, vol. 3, no. 2, pp. 99-103.

Intensive care units have become an established and essential service for the management of critically ill patients over the last 10 years. During the same period a new nursing management structure has been introduced and a reorganization of the National Health Service has taken place. The effect of these three developments on

intensive care nursing are discussed, with particular reference to training and to stresses on intensive care nurses. The qualities required of an intensive care nurse are of a high order and this must be fully understood by those responsible for selection. Mature personalities, clear lines on individual responsibilities, a regard for each others' professional skills, easy communication, and an acceptance of colleagues' views are essential. The period of time a registered nurse stays in intensive care is self-limiting. Those who do not wish to make it their career will gain valuable experience which will enable them to deal confidently with emergencies in other areas of nursing.

285. ROBINSON, W. **Running an intensive care unit.** *Middle East Health & Supply Service*, Sutton, 1977, Aug./Sept., vol. 1, no. 8, pp. 12-14.

The intensive care unit at the new Charing Cross Hospital is one of the most up-to-date in the world. It is designed to accommodate men and women who need continuous medical and nursing care. It has a large open ward area with three beds, four single rooms and an over-night doctor's room. The highly specialized equipment ensures that continuous observations can be made and various design features, including hatches leading from the patient rooms to the sluice, lessen the risk of cross infection. The intensive care unit has a large storeroom and two emergency trolleys. An intercom system enables a nurse to summon help without leaving the patient's bedside. The medical management of the unit is under the overall supervision of a director, who is a consultant anaesthetist, and 25 nurses and eight students rotate their duties in shifts. Patients admitted include those who have had open heart surgery, are suffering from severe respiratory and neurological conditions, or are in a state of acute renal failure. The demands of this type of nursing are considerable, and any intensive care unit must be spaciously planned and equipped to a very high standard.

286. CULLEN, D. J. **Results and costs of intensive care.** *Anesthesiology*, Philadelphia, 1977, Aug., vol. 47, no. 2, pp. 203-216.

Intensive care uses enormous resources, but outcome data are scanty and those available are specific to each unit's experience. The purpose of this paper is to demonstrate that: (i) intensive care offers real but limited value; (ii) conventional (as opposed to intensive) care is unlikely to result in comparable survival rates; (iii) the means are already available or becoming available to document results of intensive care in comparable groups of patients; and (iv) the medical community can be provided with the data and guidelines necessary for viewing the medical commons and appropriately deciding how it will be shared. After discussing the definition of critical illness, the function of the intensive care unit (ICU) and the ICU population, the author reviews the results and costs of intensive care in critically ill patients at Massachusetts General Hospital, Boston. The implications of the findings are discussed.

287. POZEN, M. W. and others. **The outcome of pre-hospital life-threatening arrhythmias in patients receiving electrocardiographic telemetry and therapeutic interventions.** *American Journal of Public Health*, Washington, 1977, June, vol. 67, no. 6, pp. 527-531.

Patient delay in seeking medical assistance for acute ischaemic heart disease and the incidence of potentially life-threatening arrhythmias en route to the hospital were

examined in a 22-month community trial of ambulance telemetry. Of 7,654 patients transported, 179 who had electrocardiograms transmitted were found to have acute myocardial ischaemic events. Fifty per cent of these patients. summoned an ambulance within 30 minutes and 72 per cent within two hours after the onset of acute symptoms. Fifty-eight patients had potentially life threatening arrhythmias. Interventions with drugs and/or defibrillation was required in 22 patients with or without cardiopulmonary resuscitation. Twelve of these 28 patients survived hospital admission and six were still alive three months later. The relatively low outcome/input ratio of this experience necessitates re-evaluation of the epidemiological characteristics and patient selection criteria in populations considered for telemetry.

288. POZEN, M. W., FRIED, D. D. and VOIGT, G. G. **Selection of patients for ambulance telemetry.** *American Journal of Public Health*, Washington, 1977, June, vol. 67, no. 6, pp. 532-535.

One hundred and eighty-two out of 1,928 patients (9.4 per cent) transported by ambulance during a six-month period in Baltimore had ECGs transmitted. A review of the remaining 1,746 records by two cardiologists indicated that an additional 113 patients should have had their ECGs transmitted because of life-threatening conditions. Of patients with acute ischaemic heart disease, 47 had ECG monitoring and 24 did not. There were 22 per cent more Killip III/IV patients with a 19 per cent higher mortality at three months among the 'non-transmitted' patients as compared to the 'transmitted' patients, controlling for all other relevant variables. Critical presentations inappropriately affect ambulance staffs' selection of patients for monitoring.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

289. MCKEE, I. **A new look at antenatal care.** *World Medicine*, London, 1977, Sept. 21, vol. 12, no. 25, pp. 72, 75-77, 79.

A pilot study to develop an efficient antenatal service for all sections of the community was set up at the Sighthill Health Centre in Edinburgh. The service is a partnership with the specialist helping the general practitioner and the practitioner sharing in the preparation of his patient for a hospital confinement. On a clinic day, a senior midwife and four pupils from the hospital bring the notes of the antenatal patients registered with the two participating practices at the centre. Three district midwives are based at the centre. Patients book into the hospital from the clinic but only visit it for a familiarization visit or procedures such as ultrasonic scanning. The general practitioner is the clinic team leader, but the specialist is on hand to deal with problems without hospital referral. To make clinical information readily available to the team, a 'risk card' has been developed and certain factors on the card lead to certain procedures being followed. All results of investigations are sent to the hospital. The scheme has reduced significantly the non-attendance rate for antenatal visits. The experience at Sighthill shows that the efficiency of modern scientific procedures in antenatal care can be combined with care by a health centre team to give a personalized antenatal service.

CASUALTY AND ACCIDENT

See also Abstract No. 209

290. DRURY, L. R. and ROSEN, P. **Multiple use, flexibility key emergency department planning.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 201-202, 205-206, 208-211.

Although many emergency departments have proved to be inadequate for both the volume of work and the types of patients seen, one solution has not received proper attention—relating the architectural design to the department's functions. In this paper this approach to architectural design is based on the functions of emergency departments, which have many functions in common, but which vary in size and in demands on space, equipment and staff. Furthermore, this approach stresses that facilities should not be duplicated and that all areas should be planned for flexibility and multiple use. Some general and appropriate points about planning are: a triage system manned by trained medical staff is essential; actual space requirements for examination and treatment are quite minimal compared with those for waiting areas; flexibility in the design to allow for major changes, which inevitably will occur, is important; and organization and team-effort ensure efficiency which the architect enhances. Detailed recommendations are made on the various areas and rooms in the department.

291. WEBB, S. B., TAYLOR, W. J. and CANNON, J. **How full-time ED physicians affect admissions.** *Hospital Medical Staff*, Chicago, 1977, July, vol. 6, no. 7, pp. 24-28.

Different resources are needed to deal with emergency as distinct from scheduled patients and the proportion of admissions from the emergency department has an important influence on the planning of resources and the control of costs. A study was carried out to assess the influence of the introduction of full-time emergency physicians on the emergency admissions at a 275-bed community hospital. The study showed that the presence of full-time physicians in the emergency department controlled the accelerating rate of admissions, but, as predicted, had no effect on the increasing emergency department visits. Results are given in two tables.

292. LUCATTELLI, C. C. and MORI, G. C. Cellula mobile di emergenza extraospedaliera (nell'ipotesi di una riforma globale sanitaria). **[Emergency mobile cells outside the hospital.]** *Tecnica Ospedaliera*, Roma, 1977, June, vol. 7, no. 6, pp. 19-35.

The authors present their design for a mobile ambulance/emergency operating theatre. They first describe in some detail the research on which their design is based, and there are 18 figures which illustrate the stages in research and the features of the 'cell'. The patient's bed is mounted on a column in the centre of the body of the ambulance; the lower part of the column contains a gas suspension system to minimise the effects of vibration while the vehicle is moving, and the upper part contains an electronically operated piston apparatus which allows the bed to be raised, lowered, or inclined. The vehicle is air-conditioned and it is designed to carry equipment for

emergency use including ECG equipment, a defibrillator, an automatic respirator, surgical instruments, and a thermostatically controlled cradle for emergency obstetric cases.

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 177

CHILDREN

See also Abstract No. 261

293. NOBLE, E. **Hospital schools and parental involvement.** *NAWCH News*, London, 1977, vol. 1, no. 2, pp. 7-8.

This paper presents the case for involving parents in the teaching of their children while in hospital. Advantages of parent participation include: (i) parents are better able to understand the aims of the school and the purpose of activities; (ii) children appreciate having their mothers at hand to help them; (iii) the teacher is freed to give more time to individual tutoring. Siblings can also be drawn into sharing activities with patients, an important part of keeping the family together. Successful parent partnership depends on good communication. Some difficulties are mentioned. Hospital schools which allow parental visiting during school hours have not found themselves overwhelmed, though teachers are not alone in finding it difficult to work under what they may feel to be the critical eyes of parents.

294. La psychiatrie de l'enfant au Québec. **[Child psychiatry in Quebec.]** *Revue de Neuropsychiatrie Infantile et d'Hygiène Mentale de l'Enfance*, Paris, 1977, May/June, vol. 25, nos. 5/6, pp. 295-371.

A series of eight papers with an introduction, designed to illustrate for French readers current trends in child psychiatry in the Province of Quebec. The topics dealt with are: (i) the mental health team in the paediatric hospital; (ii) experience of child psychiatry in a nursery school; (iii) modernization of a traditional psychiatric hospital; (iv) placebo effect of psychotropic drugs on patients and staff; (v) psychiatric intervention in a school environment; (vi) re-educative techniques in an institutional environment; (vii) psychiatric case record organized as a function of the problems raised by the patient; and (viii) the value of child psychiatry in Quebec.

295. SNOOK, H. **The use of Glasgow hospital beds by children under the age of one year.** *Child Care Health and Development*, Oxford, 1977, May/June, vol. 3, no. 3, pp. 165-173.

In Scotland, details of all hospital discharges are recorded and stored centrally by the Information Services Division of the Common Services Agency. This paper presents part of the data derived from ad hoc tabulations relating to Glasgow. The data relates to discharges, not to individuals, so that discharge rates are inflated by recurrent discharges and by transfers. Total births in the appropriate calendar year were used to obtain discharge rates. The study showed a 50 per cent rise in the number of discharges per 1,000 births from 1968 to 1972. This was attributable to increased

rates for infections of the alimentary and respiratory systems. There was no evidence of a rise in disease prevalence nor a fall in mortality rates. It is hypothesized that hospital resources may be used inappropriately to meet demand when the actual need is for primary care services.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 275, 307

296. NORTON, D. **The elderly: a challenge to nursing—1. Geriatric nursing—what it is and what it is not.** *Nursing Times*, London, 1977, Oct. 20, vol. 73, no. 42, pp. 1622-1623.

This article is the first of a series of 16 that will consider all aspects of caring for the elderly. In this introductory article the history and development of geriatrics are examined. The social environment, the lack of support services and poor quality nursing staff caring for the elderly prior to the acceptance of geriatrics in the 1940's are discussed. The impact of the introduction of the practice of geriatrics, imposed upon unsuitable facilities and physical environment, and the call to get patients away from the bed caused a revolution in care which was to disrupt nursing routines and procedures. The result was that many old people found that they simply exchanged the bed for the chair. Recently, with a change in attitudes towards many of the chronic clinical conditions and a greater understanding of gerontological problems, it has been possible to improve the quality of life of geriatric patients. Ideally, geriatric nursing should exist in the context of 'the team'. The lack of facilities and support services often means that this is not possible but a positive approach to the problems of geriatric nursing can lead to an improvement in the patient's lifestyle.

297. ROBERTS, I. **Should geriatric nursing be a specialty?** *Nursing Times*, London, 1977, Oct. 6, vol. 73, no. 40, pp. 1566-1568.

This article is based on a paper given at the Developments in Nursing Conference, Liverpool University, in September 1976, and questions the value of regarding the care of the elderly as a speciality. It suggests that old age, in itself, is not pathological, and that the identification of the elderly as a dependent or deprived group in order to direct the necessary caring and social services can obscure their usefulness to the community. Whilst the numbers of the elderly increase, so do the numbers of dependent elderly persons requiring high levels of care. In questioning the importance of geriatric nursing as a speciality it is suggested that the skills required are much the same as for any other high dependence group, and furthermore, it may be imposing unwelcome or incorrect stereotypes on the person being cared for or inhibit effective communication. The article concludes with a plea to regard the patient as a whole person and not as a member of a particular class or group.

298. BURROWS, J. **The elderly: a challenge to nursing—2. The elderly in our society.** *Nursing Times*, London, 1977, Oct. 27, vol. 73, no. 43, pp. 1670-1674.

This is the second article in a series dealing with the elderly, and it examines the place of the elderly in society. The projected increase of the 75 + age group is shown and the strain this will place on existing services illustrated. Over the next decade it is

expected that the 75+ age group will expand by 20 per cent, comprising individuals who are likely to become increasingly dependent upon health and social services with little family support, many social problems and a high level of deprivation. In view of this increase in the numbers of elderly persons, the health and social services will have to expand rapidly and consider re-distributing existing services and manpower as well as re-evaluating policy on the care of elderly persons, their social problems and the ageing process.

299. MORGAN, D. M. **Extendicare/Scarborough: more than a place to live.** *Dimensions in Health Service*, Toronto, 1977, Aug., vol. 54, no. 8, pp. 35-37.

Extendicare Limited, the largest Canadian publicly-owned chain of nursing homes, owns, leases or manages 52 facilities representing 6,486 beds, and its high standard of care and good management is nowhere more evident than at Extendicare, Scarborough, near Toronto. This modern building has 155 beds in 70 two-bedded rooms, three rooms with four beds and three single rooms. The home also contains three nursing units, offices for administration and the director of nursing, a large occupational therapy room and a beauty salon. Families of residents are encouraged to include their relatives in family outings. The home is staffed beyond the requirements of the Ontario Nursing Homes Act, and is supplied with support staff from the head office of Extendicare Limited. Each home administrator reports to a regional manager and takes a 20-week course in nursing home administration before taking up his post. Each patient is treated as an individual and encouraged to enjoy life and maintain self reliance. The few capable of returning home can visit the home's day care centre.

300. ROBINSON, W. **Royal Hospital and Home for Incurables.** *Nursing Mirror*, Sutton, 1977, Sept. 15, vol. 145, no. 11, pp. 16-19.

The Royal Hospital and Home for Incurables, founded in 1854, now provides accommodation for 205 patients in the main hospital in Melrose Hall, Putney, with facilities for 30 young disabled people in the modern Chatsworth Wing. About £200,000 is currently being spent on modernizing the main hospital. The criteria for admission are that patients should be incurably disabled and with no one to look after them; 84 patients have multiple sclerosis and others Parkinson's disease, Friedreich's ataxia and spastic paralysis. Physiotherapy is given and the occupational therapy department supplies special aids and encourages activities. Art classes and music therapy are also provided. There are from one to six patients in each room, grouped together in wards of 28, with two ward sisters. The RHHI is an independent hospital, but 150 beds are supported by the National Health Service and legacies and bequests supplement patients' contributions. Medical emergencies are dealt with by local general practitioners and a panel of consultants visits the hospital. The nurses need to become involved in the total care of the patient and last year the matron ran a course for State Registered Nurses on residential care for the disabled. The hospital is in the process of appointing a chief medical and research officer.

301. LOCKE, S. S. **Education for the long-term care administrator: one student's perspective.** *Journal of Long-Term Care Administration*, Washington, 1977, vol. 5, no. 2, pp. 59-77.

Statistics indicate that there are increasing numbers of both geriatric and long-stay patients. Consequently, there is a need for trained administrators to manage the

facilities which will care for these individuals. This paper concentrates on the care element of a health care organizational model—the patient. It attempts to identify the characteristics of the long-stay patients, his or her resultant multiple needs and the requirements placed on the facility and its administrator to deal with those needs. Three characteristic skills common to all types of management are human, technical and conceptual. Depending on the manager's level in the organization, he will draw on certain skills more than others. The nursing home administrator may intermix all three skill areas to a greater extent than other health care administrators. However, he will most frequently use conceptual skills—the ability to see the total organization and its relationship to the external environment. In order to develop those skills, educators should work from a model which emphasizes the patient and his needs. The proposed model is used here as a point of departure from which the educator can discuss the internal and external resource planning and programming necessary for the operation of a long-stay care facility.

302. CHOW, R. K. **Development of a patient appraisal and care evaluation system for long-term care.** *Journal of Long-Term Care Administration*, Washington, 1977, vol. 5, no. 2, pp. 21-27.

A fully tested, uniform system of health care appraisal of individual patients is the key to improving the quality of care. For this reason, in February 1976 the United States Department of Health, Education and Welfare launched a national programme to develop a patient appraisal and care evaluation (PACE) instrument as a part of the second phase of its long-term care facility improvement campaign. In using the PACE method, the care provider observes and records data about patient characteristics and his or her functional capacity, as well as planning for the individual's care in a logical, systematic way. The appraiser sets time-limited goals and, subsequently, determines whether or not those goals have been met by the facility's staff. This paper describes the development of PACE and how it is being developed. It also discusses potential future uses and some important steps that have to be taken.

303. DENNIS, L. C., BURKE, R. E. and GARBER, K. M. **Quality evaluation system: an approach for patient assessment.** *Journal of Long-Term Care Administration*, Washington, 1977, vol. 5, no. 2, pp. 28-51.

The paper describes briefly the development of the quality evaluation system (QES) for long-stay care explaining the choice of non-physical health measures and the way in which cluster analysis is used to select the most discriminating items and to group them into scales. Tests of QES were conducted in 150 long-stay care facilities in Illinois with a sample of more than 1,300 patients. The results of these tests are summarized. They show that QES is a valid instrument which may be valuable both in certification/licensure and in providing quality measures for reimbursement incentives. QES also has substantial potential for use as a management tool with which providers can assess quality independently and take remedial action when needed. Because the QES approach to patient assessment focuses on care in terms of the needs of patients, it more nearly than any previous methodology measures facility quality in relation to its true effectiveness in care delivery.

NEUROLOGY AND NEUROSURGERY

304. MOODY, A. **Specialised care 1. Care of the stroke patient.** *Nursing Mirror*, Sutton, 1977, Sept. 1, vol. 145, no. 9, nursing care supplement, pp. 1-4.

Many people suffer strokes, the majority being over 50 years of age, and it is the task of the entire health team to develop every bit of potential shown by those who survive. The doctor's task is to try to reach a diagnosis and, if possible, treat the cause. The early involvement of relatives in planning the patient's care is vital. The care of the unconscious patient includes accurate recording of observations, maintenance of a clear airway, turning the patient and administering passive exercises. As the patient gets better, he should sit in a chair and be encouraged to help himself as much as possible, with special attention to the use of the affected side of his body. The occupational therapist, physiotherapist and the nurse need to work closely together in the process of rehabilitation and the psychological aspect cannot be stressed too much. If there is a speech defect, some means of communication must be found. Care at home is given by the various community services and the setting up of stroke clubs helps the problem of socialization.

CARDIOLOGY

See also Abstract Nos. 221, 287, 288

305. BONJER, F. H. and JONKERS, A. H. Het COPIH project 1971-1974. I: Aanleiding, opzet, en uitvoering. **[The COPIH project 1971-1974. I: Background, design methods and procedures.]** *Tijdschrift voor Sociale Geneeskunde*, Amstelveen, 1977, Sept. 14, vol. 55, no. 18, pp. 658-663.

The increase in coronary heart disease, particularly between the years 1965 and 1969, prompted the setting up of the COPIH project for the detection and prevention of ischaemic heart disease Its object is to research into known and suspected risk factors among workers in industry. The paper describes the method of research. Voluntary participants are asked by questionnaire about their history of heart and other diseases, smoking habits, heredity, psychosocial factors etc. A physical examination follows including electrocardiogram, measuring of body weight and blood pressure, blood and urine tests The results are selectively and by weekly routine fed into a computer which stores all data and produces scores for a coronary risk profile (fig. 1). These are subsequently presented in a decision tree (fig. 2) indicating the need for nutritional and medical advice. Stress is laid on standardization of instruments and measures and on quality control through regular instrument testing, instruction and refresher courses for staff and use of a reference laboratory. Quality control of chemical analyses and of ECG's coding (Minnesota code) are handled by separate organizations (KCA and SEAL respectively). At the end of each calendar year all data are made available to the COPIH organization. The programme is sponsored and largely financed by industry with some Government assistance. More details are given. The paper includes a list of references and of industrial medical services associated with the programme.

306. TOTH, A. and TOTH, S. **Post-coronary patients receive group therapy.** *Hospital Progress*, St. Louis, 1977, Aug., vol. 58, no. 8, pp. 72-75.

Sisters of Charity Hospital, Buffalo, N.Y., instituted a post-coronary group therapy programme in which patients could discuss the fears and anxieties generated by their coronary illness. The programme, attended by patients and spouses together, is conducted by a cardiac teaching nurse and the social service director. It consists of 10 one-and-a-half-hour sessions over a 10-week period. The two basic elements of the programme are health education and group therapy. It covers: description of cardiac problems; education about physiology and surgery; risk factors; anxiety; role of the spouse; diet; and discussion of problems.

307. ZDICHYNEC, B. Erfahrungen mit der Frühmobilisation des Herzinfarktes im hohen Alter. **[Experiences with the early mobilization of elderly patients with myocardial infarction.]** *Rehabilitation*, Stuttgart, 1977, Aug., vol. 16, no. 3, pp. 157-161.

Patients with myocardial infarction undergoing a multi-stage activation scheme, according to WHO recommendations, consisting of five basic phases, can be mobilised in about 85 per cent of the time within the first 20 days of hospitilisation and about 55 per cent of the time in the second week after the attack. The average hospital stay is four weeks. In the hospital phase the early mobilised patients showed a decrease in early mortality and complications, e.g. reinfarction, heart rupture, development of aneurysm, cardiac insufficiency, thromboembolism and heart arrhythmia, compared with 190 patients of the same age who were under traditional bed rest and anticoagulation therapy.

UROLOGY

See Abstract No. 180

MATERNITY

See Abstract No. 289

PSYCHIATRY

See Abstract Nos. 167, 259, 283, 294, 299

308. MANSFIELD, C. D., and SIKKING, B. J. **Staff, responding to enquiries, admits psychiatric patients.** *Hospitals*, Chicago, 1977, July 16, vol. 51, no. 14, pp. 187-188, 190.

As part of financial economies at the 115-bed Upham Hall, a psychiatric facility of Ohio State University Hospitals, the post of admitting clerk was abolished and social workers became responsible for the complete admission procedure. The duties are shared by the few social workers on the adult in-patient units and the director of social work, each being responsible for one day a week from 0800 to 1630. The social worker on duty devotes the whole day to this assignment. Admissions occurring in the evenings and at week-ends (about 15 per cent of the total) are made directly from

the emergency department. The procedures followed are described and the advantages of the new system are discussed, with particular reference to increased occupancy.

309. MEDOUZE, R. M. Eléments pour une réflexion sur l'hospitalisation des détenus. **[Some thoughts on the hospitalization of prisoners.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1977, Aug./Sept., vol. 32, nos. 383/384, pp. 83-85.

No specific structure at present exists in France for the hospital treatment of prisoners. It is generally agreed that supervision of prisoners in hospital is extremely difficult despite the sometimes heroic efforts made by the police, and the presence of warders or policemen in a ward for 24 hours a day can be distressing for the other patients. There are two possible solutions to this problem: either to establish a hospital unit inside the prison, or to establish a special prisoners' unit within the hospital. The latter solution seems preferable, and provision should be made in hospital investment programmes for the creation of a unit which would communicate directly but discretely with the hospital's emergency department.

310. BURVILL, P. W. **Psychiatric units in general hospitals.** *Medical Journal of Australia*, Glebe, 1977, July 9, vol. 2, no. 2, pp. 57-59.

Psychiatric units in general hospitals will, increasingly, play a larger part in the delivery of psychiatric services to the community. Australian units are compared with those in England and Wales. It is very difficult to envisage the widespread adoption in Australia of large comprehensive district general hospital psychiatric units similar to those planned for Great Britain. A current challenge to existing psychiatric units in the large teaching hospitals in the capital cities of Australia is whether they will take on a catchment area responsibility, or remain independent of any plans for regionalization of psychiatric services.

311. CAMPBELL, W. **Looking at the when and why of staff turnover.** *Health and Social Service Journal*, London, 1977, Sept. 9, vol. 87, no. 4557, pp. 1272-1273.

This four-year study of staff turnover in a small psychiatric unit was undertaken to establish how many nursing staff left the unit, the possible reasons, and whether a seasonal pattern would emerge. All grades from nursing assistant to nursing officer were included in the study and the reasons for leaving were sought in an informal interview upon termination of employment. The reasons given were then classified under seven headings: promotion or retirement; further education; ill health; unsuitability; dissatisfaction; and miscellaneous reasons. It was originally thought that promotion or advancement was the commonest reason for leaving; however it was discovered that those leaving because they were dissatisfied equalled those who left for promotion.

312. GOODMAN, E. **Compulsory admission of the mentally ill.** *Medical Journal of Australia*, Glebe, 1977, June 25, vol. i, no. 26, pp. 964-965.

An exception to the requirement of consent before treatment arises where the patient is mentally ill. The admission of such patients to an admission centre is controlled in Australia by legislation which, together with the definition of mental illness, varies

somewhat from state to state. Imprecise legislation may give rise to a serious dilemma for the doctor. A study carried out in New South Wales in 1966 revealed that only 34 out of 100 patients admitted to one centre were suffering from mental illness within the meaning of the New South Wales Mental Health Act. To overcome this problem, proposals were set out to include psychopathic disorders, and alcohol and drug dependence within the definition of mental illness. However, to protect patients' rights it is essential that a patient committed involuntarily for a long period has the benefit of legal representation before a magisterial enquiry. Such a hearing does take place in New South Wales, but the patient is not legally represented and a relative has no right to be present. Changes in this system would not only benefit the patient, but protect the admitting officer in the event of a patient challenging his involuntary admission.

313. BEREZOWSKY, J. B. Le soin du malade psychotique en état de crise. [**The care of psychotic patients in crisis.**] *Infirmière Canadienne*, Ottawa, 1977, Sept., vol. 19, no. 19, pp. 26-29.

Since staff in general hospitals may be unaccustomed to psychotic patients, the author profers practical advice on how to deal with a psychotic patient who is admitted in a state of crisis. She describes the drug treatment which is generally given and suggests that the initial dose be given intramuscularly or intravenously. Three to six members of staff should be present when the initial dose is given, in case the patient becomes violent. Drugs should be given every four hours for the first 48-72 hours; the patient's pulse, respiration, and blood pressure should be monitored regularly and he should be helped to take a little exercise. The nurse should always tell the patient what she is going to do before approaching him and her attitude should be firm but positive. The patient should be undressed as soon as possible and his clothes locked up since he is likely to attempt to run away. His bed should be a low one in case he falls out. Finally, other patients in his vicinity should have the situation and the proposed action explained to them simply and clearly.

314. LUCAS, R. W. and others. **Psychiatrists and a computer as interrogators of patients with alcohol-related illnesses: a comparison.** *British Journal of Psychiatry*, Ashford, 1977, Aug., vol. 131, pp. 160-167.

A computer-administered 'interview' for eliciting evidence relating to alcohol problems was developed in the alcohol clinic of the Southern General Hospital, Glasgow. The programme of questions was based on the routine clinical interview in use in the clinic. Thirty-six volunteer male patients on their first visits to a specialist alcohol clinic were interviewed three times, by two psychiatrists and by the computer; information was sought about 72 pre-defined indicants concerning alcohol consumption, drinking behaviour, and symptoms. Each patient was asked to complete an attitude questionnaire. The extent of agreement between the evidence elicited by the computer and by the psychiatrists was quite high, and their estimated error rates were very similar. With respect to amounts of alcohol consumed, patients reported significantly greater amounts to the computer than to the psychiatrists. The results from the attitude questionnaire indicated a high level of acceptability to patients of computer interrogation.

315. MITTLER, P., editor. **Research to practice in mental retardation: Fourth Congress of the International Association for the Scientific Study of Mental Deficiency [IASSMD]. Volume I. Care and intervention.** Baltimore & London, University Park Press 1977, xxiv, 472pp. £17.50

This is the first of three volumes based upon the proceedings of the Fourth Congress of the International Association for the Scientific Study of Mental Deficiency. It focuses upon developments in service provision with particular emphasis on early intervention and multidisciplinary treatment. This volume has 58 chapters in nine main sections. The sections cover: research and policy; attitudes; ethical and related issues; epidemiology; early intervention; working with families; residential services; community services; psychiatric services; and cost-effectiveness analysis. An author index and subject index are included together with the contents of the other two volumes.

316. MASTERS, A. **Bedlam.** London, Michael Joseph, 1977, 206pp. £6.50

The author presents a social history of the plight of the insane in society using as a pivot for his views Bethlem Hospital, the most famous institution for the insane in Britain. The efforts of some of the men who fought for reform, the accidents of history that gave them impetus and the gradual progress towards a more humane and compassionate treatment of the insane are chronicled. Three appendices and a bibliography are included together with a large number of illustrations.

317. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **The facilities and services of mental illness and mental handicap hospitals in England 1975.** (Statistical and Research Report Series No. 19) London, HMSO, viii, 131pp. £4.00

This Report presents information about the facilities and services provided by mental illness and mental handicap hospitals and units in 1975. The main source of the information is the statistical return SBH 112 completed by each hospital providing a service for the mentally ill or mentally handicapped and submitted to the Department of Health and Social Security annually. A list of official publications on psychiatric statistics since 1949 is presented in an appendix.

318. AVON. COUNTY COUNCIL. SOCIAL SERVICES DEPARTMENT. **Mental health admissions: Mental Health Act 1959 (as amended).** Bristol, Avon County Council, Social Services Department, 1977, 45pp. £1.50

This handbook represents a combination of legal requirements relating to the Mental Health Act 1959 and the policy of Avon County Council and as such it forms the basis for professional practice within the social services department, throughout the county. Aspects covered include: receiving and dealing with referrals; admissions to hospital; general duties, powers and responsibilities of applicants and mental welfare officers in admissions. Four appendices are included covering: procedures for obtaining emergency psychiatric advice; algorithms for admission; definition of mental disorder; and a map of the county of Avon.

319. GLOSSOP, C. and others. **Comparative evaluation of locally-based and 'traditional' hospital units for the mentally handicapped in Wessex: (1) contacts made by 'external professionals' with clients resident in the units; (2) morbidity experienced by the clients.** (Research report no. 127) Winchester, Health Care Evaluation Research Team, [1977], [iii], 114pp.

This report is concerned with the contact rate of 'external professionals' with mentally handicapped clients living in residential facilities. The arrangements made by planners to ensure the availability of certain categories of service professionals who have skills in the resolution of problems of people categorized as mentally handicapped and their families are assessed, together with morbidity rates. The method of analysis is outlined and the results analysed and discussed. Two appendices are included: (i) measurement sources of data, definitions, rules for abstraction and method of presentation; and (ii) the recording forms used in the collection of data. There is also a bibliography.

320. SCHINKE, S. P. and WONG, S. E. **Evaluation of staff training in group homes for retarded persons.** *American Journal of Mental Deficiency*, Albany, 1977, Sept., vol. 82, no. 2, pp. 130-136.

Staff in 12 group homes for the mentally handicapped in the Seattle area were randomly assigned to either an experimental group, (six homes) receiving eight 1.5-hour training sessions in behaviour modification, or a waiting-list control group (six homes). The impact and effectiveness of training was measured by four outcome instruments administered at pre- and post-training assessment periods: knowledge test; attitude checklist; job-satisfaction rating; and naturalistic observation. The scores showed that, compared to control home staff, experimental home staff increased significantly more in knowledge of behavioural techniques, had better evaluations of their residents, and indicated less decline in job satisfaction. Naturalistic observational data, collected with continuous real-time recording devices, showed trained staff to be superior in correctness and latency of their responses to residents. Trained staff homes also had significantly greater increases in the frequency and duration of positive staff and resident behaviour.

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